LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: C.R. Gilbert ₵
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Representative James A. Dunnigan proposes the following substitute bill:

1 **DEPARTMENT OF INSURANCE AMENDMENTS**
2 2018 GENERAL SESSION
3 STATE OF UTAH
4 **Chief Sponsor: James A. Dunnigan**
5 Senate Sponsor: Curtis S. Bramble
6
7 **LONG TITLE**
8 **General Description:**
9 This bill modifies provisions of the Insurance Code.
10 **Highlighted Provisions:**
11 This bill:
12 ▸ defines terms and modifies defined terms;
13 ▸ addresses the requirements for filing a binder for a health benefit plan or dental
14 policy with the commissioner;
15 ▸ modifies the date on which the commissioner presents an annual evaluation of the
16 state's health insurance market;
17 ▸ classifies certain records related to an examination as protected records;
18 ▸ modifies the process by which the commissioner determines an applicant's ability to
19 provide proposed health care services under Title 31A, Chapter 8, Health
20 Maintenance Organizations and Limited Health Plans;
21 ▸ modifies the requirements for Ĥ→ **[~~an unauthorized~~]** **a nonadmitted** ←Ĥ insurer to be
21a listed on the
22 commissioner's "reliable" list;
23 ▸ provides the circumstances under which the commissioner must hold a hearing on a
24 merger or other acquisition of an insurer;
25 ▸ amends the deadline for holding a hearing on a merger or other acquisition of an

26 insurer;
27 ▸ allows an insurer to terminate coverage of a spouse of an insured under an accident
28 and health insurance policy in the event of legal separation;
29 ▸ prohibits an insured from charging any additional amount for electing to extend
30 group coverage;
31 ▸ addresses the timing of open enrollment for individuals who extend or are eligible
32 to extend group coverage;
33 ▸ provides that the commissioner may take action against a licensee if the
34 commissioner finds that the licensee is convicted of a misdemeanor involving fraud,
35 misrepresentation, theft, or dishonesty;
36 ▸ modifies the training and continuing education requirements for certain licensees;
37 ▸ amends provisions related to the effect of an insurer's insolvency;
38 ▸ clarifies the process by which the state designates the essential health benefits for
39 the state;
40 ▸ repeals certain sections of the Insurance Code; and
41 ▸ makes technical and conforming changes.
42 **Money Appropriated in this Bill:**
43 None
44 **Other Special Clauses:**
45 None
46 **Utah Code Sections Affected:**
47 AMENDS:
48 **31A-1-301**, as last amended by Laws of Utah 2017, Chapter 292
49 **31A-2-201.1**, as last amended by Laws of Utah 2008, Chapter 382
50 **31A-2-201.2**, as last amended by Laws of Utah 2017, Chapter 292
51 **31A-2-204**, as last amended by Laws of Utah 2008, Chapter 382
52 **31A-3-303**, as last amended by Laws of Utah 2011, Chapters 62 and 275
53 **31A-8-104**, as last amended by Laws of Utah 1997, Chapter 185
54 **31A-8a-102**, as last amended by Laws of Utah 2013, Chapters 104 and 135
55 **31A-15-103**, as last amended by Laws of Utah 2017, Chapter 363
56 **31A-16-103**, as last amended by Laws of Utah 2015, Chapter 244

57 **31A-22-612**, as last amended by Laws of Utah 2015, Chapter 244
58 **31A-22-618.6**, as last amended by Laws of Utah 2017, Chapter 168 and renumbered
59 and amended by Laws of Utah 2017, Chapter 292
60 **31A-22-629**, as last amended by Laws of Utah 2012, Chapter 253
61 **31A-22-701**, as last amended by Laws of Utah 2017, Chapter 168
62 **31A-22-722**, as last amended by Laws of Utah 2013, Chapter 319
63 **31A-23a-107**, as last amended by Laws of Utah 2012, Chapter 253
64 **31A-23a-109**, as last amended by Laws of Utah 2012, Chapter 253
65 **31A-23a-111**, as last amended by Laws of Utah 2017, Chapter 168
66 **31A-23a-208**, as enacted by Laws of Utah 2013, Chapter 341
67 **31A-23b-102**, as last amended by Laws of Utah 2017, Chapter 168
68 **31A-23b-202.5**, as last amended by Laws of Utah 2017, Chapter 168
69 **31A-23b-204**, as enacted by Laws of Utah 2013, Chapter 341
70 **31A-23b-205**, as last amended by Laws of Utah 2014, Chapters 290, 300, 425 and last
71 amended by Coordination Clause, Laws of Utah 2014, Chapters 300, and 425
72 **31A-23b-206**, as last amended by Laws of Utah 2015, Chapter 244
73 **31A-25-204**, as enacted by Laws of Utah 1985, Chapter 242
74 **31A-25-206**, as last amended by Laws of Utah 2001, Chapter 116
75 **31A-26-102**, as last amended by Laws of Utah 2014, Chapters 290 and 300
76 **31A-26-205**, as last amended by Laws of Utah 1986, Chapter 204
77 **31A-26-208**, as last amended by Laws of Utah 2011, Chapter 284
78 **31A-27a-111**, as enacted by Laws of Utah 2007, Chapter 309
79 **31A-27a-608**, as enacted by Laws of Utah 2007, Chapter 309
80 **31A-43-303**, as last amended by Laws of Utah 2014, Chapters 290 and 300
81 **63G-2-305**, as last amended by Laws of Utah 2017, Chapters 374, 382, and 415
82 ENACTS:
83 **31A-45-403**, Utah Code Annotated 1953
84 REPEALS:
85 **31A-22-722.5**, as last amended by Laws of Utah 2011, Chapters 297 and 340
86 **31A-30-209**, as last amended by Laws of Utah 2016, Chapter 138
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88 *Be it enacted by the Legislature of the state of Utah:*

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

90 **31A-1-301. Definitions.**

91 As used in this title, unless otherwise specified:

92 (1) (a) "Accident and health insurance" means insurance to provide protection against

93 economic losses resulting from:

94 (i) a medical condition including:

95 (A) a medical care expense; or

96 (B) the risk of disability;

97 (ii) accident; or

98 (iii) sickness.

99 (b) "Accident and health insurance":

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

101 (A) an income replacement contract;

102 (B) a health care contract;

103 (C) an expense reimbursement contract;

104 (D) a credit accident and health contract;

105 (E) a continuing care contract; and

106 (F) a long-term care contract; and

107 (ii) may provide:

108 (A) hospital coverage;

109 (B) surgical coverage;

110 (C) medical coverage;

111 (D) loss of income coverage;

112 (E) prescription drug coverage;

113 (F) dental coverage; or

114 (G) vision coverage.

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

116 (d) For purposes of a national licensing registry, "accident and health insurance" is the

117 same as "accident and health or sickness insurance."

118 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title

119 63G, Chapter 3, Utah Administrative Rulemaking Act.
120 (3) "Administrator" means the same as that term is defined in Subsection [~~(170)~~] (171).
121 (4) "Adult" means an individual who has attained the age of at least 18 years.
122 (5) "Affiliate" means a person who controls, is controlled by, or is under common
123 control with, another person. A corporation is an affiliate of another corporation, regardless of
124 ownership, if substantially the same group of individuals manage the corporations.
125 (6) "Agency" means:
126 (a) a person other than an individual, including a sole proprietorship by which an
127 individual does business under an assumed name; and
128 (b) an insurance organization licensed or required to be licensed under Section
129 31A-23a-301, 31A-25-207, or 31A-26-209.
130 (7) "Alien insurer" means an insurer domiciled outside the United States.
131 (8) "Amendment" means an endorsement to an insurance policy or certificate.
132 (9) "Annuity" means an agreement to make periodical payments for a period certain or
133 over the lifetime of one or more individuals if the making or continuance of all or some of the
134 series of the payments, or the amount of the payment, is dependent upon the continuance of
135 human life.
136 (10) "Application" means a document:
137 (a) (i) completed by an applicant to provide information about the risk to be insured;
138 and
139 (ii) that contains information that is used by the insurer to evaluate risk and decide
140 whether to:
141 (A) insure the risk under:
142 (I) the coverage as originally offered; or
143 (II) a modification of the coverage as originally offered; or
144 (B) decline to insure the risk; or
145 (b) used by the insurer to gather information from the applicant before issuance of an
146 annuity contract.
147 (11) "Articles" or "articles of incorporation" means:
148 (a) the original articles;
149 (b) a special law;

150 (c) a charter;
151 (d) an amendment;
152 (e) restated articles;
153 (f) articles of merger or consolidation;
154 (g) a trust instrument;
155 (h) another constitutive document for a trust or other entity that is not a corporation;
156 and
157 (i) an amendment to an item listed in Subsections (11)(a) through (h).
158 (12) "Bail bond insurance" means a guarantee that a person will attend court when
159 required, up to and including surrender of the person in execution of a sentence imposed under
160 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
161 (13) "Binder" means the same as that term is defined in Section 31A-21-102.
162 (14) "Blanket insurance policy" means a group policy covering a defined class of
163 persons:
164 (a) without individual underwriting or application; and
165 (b) that is determined by definition without designating each person covered.
166 (15) "Board," "board of trustees," or "board of directors" means the group of persons
167 with responsibility over, or management of, a corporation, however designated.
168 (16) "Bona fide office" means a physical office in this state:
169 (a) that is open to the public;
170 (b) that is staffed during regular business hours on regular business days; and
171 (c) at which the public may appear in person to obtain services.
172 (17) "Business entity" means:
173 (a) a corporation;
174 (b) an association;
175 (c) a partnership;
176 (d) a limited liability company;
177 (e) a limited liability partnership; or
178 (f) another legal entity.
179 (18) "Business of insurance" means the same as that term is defined in Subsection
180 [~~(91)~~] (92).

181 (19) "Business plan" means the information required to be supplied to the
182 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
183 when these subsections apply by reference under:
184 (a) Section 31A-7-201;
185 (b) Section 31A-8-205; or
186 (c) Subsection 31A-9-205(2).
187 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
188 corporation's affairs, however designated.
189 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a
190 corporation.
191 (21) "Captive insurance company" means:
192 (a) an insurer:
193 (i) owned by another organization; and
194 (ii) whose exclusive purpose is to insure risks of the parent organization and an
195 affiliated company; or
196 (b) in the case of a group or association, an insurer:
197 (i) owned by the insureds; and
198 (ii) whose exclusive purpose is to insure risks of:
199 (A) a member organization;
200 (B) a group member; or
201 (C) an affiliate of:
202 (I) a member organization; or
203 (II) a group member.
204 (22) "Casualty insurance" means liability insurance.
205 (23) "Certificate" means evidence of insurance given to:
206 (a) an insured under a group insurance policy; or
207 (b) a third party.
208 (24) "Certificate of authority" is included within the term "license."
209 (25) "Claim," unless the context otherwise requires, means a request or demand on an
210 insurer for payment of a benefit according to the terms of an insurance policy.
211 (26) "Claims-made coverage" means an insurance contract or provision limiting

212 coverage under a policy insuring against legal liability to claims that are first made against the
213 insured while the policy is in force.
214 (27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
215 commissioner.
216 (b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent
217 supervisory official of another jurisdiction.
218 (28) (a) "Continuing care insurance" means insurance that:
219 (i) provides board and lodging;
220 (ii) provides one or more of the following:
221 (A) a personal service;
222 (B) a nursing service;
223 (C) a medical service; or
224 (D) any other health-related service; and
225 (iii) provides the coverage described in this Subsection (28)(a) under an agreement
226 effective:
227 (A) for the life of the insured; or
228 (B) for a period in excess of one year.
229 (b) Insurance is continuing care insurance regardless of whether or not the board and
230 lodging are provided at the same location as a service described in Subsection (28)(a)(ii).
231 (29) (a) "Control," "controlling," "controlled," or "under common control" means the
232 direct or indirect possession of the power to direct or cause the direction of the management
233 and policies of a person. This control may be:
234 (i) by contract;
235 (ii) by common management;
236 (iii) through the ownership of voting securities; or
237 (iv) by a means other than those described in Subsections (29)(a)(i) through (iii).
238 (b) There is no presumption that an individual holding an official position with another
239 person controls that person solely by reason of the position.
240 (c) A person having a contract or arrangement giving control is considered to have
241 control despite the illegality or invalidity of the contract or arrangement.
242 (d) There is a rebuttable presumption of control in a person who directly or indirectly

243 owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the
244 voting securities of another person.
245 (30) "Controlled insurer" means a licensed insurer that is either directly or indirectly
246 controlled by a producer.
247 (31) "Controlling person" means a person that directly or indirectly has the power to
248 direct or cause to be directed, the management, control, or activities of a reinsurance
249 intermediary.
250 (32) "Controlling producer" means a producer who directly or indirectly controls an
251 insurer.
252 (33) (a) "Corporation" means an insurance corporation, except when referring to:
253 (i) a corporation doing business:
254 (A) as:
255 (I) an insurance producer;
256 (II) a surplus lines producer;
257 (III) a limited line producer;
258 (IV) a consultant;
259 (V) a managing general agent;
260 (VI) a reinsurance intermediary;
261 (VII) a third party administrator; or
262 (VIII) an adjuster; and
263 (B) under:
264 (I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
265 Reinsurance Intermediaries;
266 (II) Chapter 25, Third Party Administrators; or
267 (III) Chapter 26, Insurance Adjusters; or
268 (ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance
269 Holding Companies.
270 (b) "Mutual" or "mutual corporation" means a mutual insurance corporation.
271 (c) "Stock corporation" means a stock insurance corporation.
272 (34) (a) "Creditable coverage" has the same meaning as provided in federal regulations
273 adopted pursuant to the Health Insurance Portability and Accountability Act.

274 (b) "Creditable coverage" includes coverage that is offered through a public health plan
275 such as:
276 (i) the Primary Care Network Program under a Medicaid primary care network
277 demonstration waiver obtained subject to Section 26-18-3;
278 (ii) the Children's Health Insurance Program under Section 26-40-106; or
279 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
280 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
281 109-415.
282 (35) "Credit accident and health insurance" means insurance on a debtor to provide
283 indemnity for payments coming due on a specific loan or other credit transaction while the
284 debtor has a disability.
285 (36) (a) "Credit insurance" means insurance offered in connection with an extension of
286 credit that is limited to partially or wholly extinguishing that credit obligation.
287 (b) "Credit insurance" includes:
288 (i) credit accident and health insurance;
289 (ii) credit life insurance;
290 (iii) credit property insurance;
291 (iv) credit unemployment insurance;
292 (v) guaranteed automobile protection insurance;
293 (vi) involuntary unemployment insurance;
294 (vii) mortgage accident and health insurance;
295 (viii) mortgage guaranty insurance; and
296 (ix) mortgage life insurance.
297 (37) "Credit life insurance" means insurance on the life of a debtor in connection with
298 an extension of credit that pays a person if the debtor dies.
299 (38) "Creditor" means a person, including an insured, having a claim, whether:
300 (a) matured;
301 (b) unmatured;
302 (c) liquidated;
303 (d) unliquidated;
304 (e) secured;

305 (f) unsecured;
306 (g) absolute;
307 (h) fixed; or
308 (i) contingent.
309 (39) "Credit property insurance" means insurance:
310 (a) offered in connection with an extension of credit; and
311 (b) that protects the property until the debt is paid.
312 (40) "Credit unemployment insurance" means insurance:
313 (a) offered in connection with an extension of credit; and
314 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
315 (i) specific loan; or
316 (ii) credit transaction.
317 (41) (a) "Crop insurance" means insurance providing protection against damage to
318 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
319 disease, or other yield-reducing conditions or perils that is:
320 (i) provided by the private insurance market; or
321 (ii) subsidized by the Federal Crop Insurance Corporation.
322 (b) "Crop insurance" includes multiperil crop insurance.
323 (42) (a) "Customer service representative" means a person that provides an insurance
324 service and insurance product information:
325 (i) for the customer service representative's:
326 (A) producer;
327 (B) surplus lines producer; or
328 (C) consultant employer; and
329 (ii) to the customer service representative's employer's:
330 (A) customer;
331 (B) client; or
332 (C) organization.
333 (b) A customer service representative may only operate within the scope of authority of
334 the customer service representative's producer, surplus lines producer, or consultant employer.
335 (43) "Deadline" means a final date or time:

336 (a) imposed by:
337 (i) statute;
338 (ii) rule; or
339 (iii) order; and
340 (b) by which a required filing or payment must be received by the department.
341 (44) "Deemer clause" means a provision under this title under which upon the
342 occurrence of a condition precedent, the commissioner is considered to have taken a specific
343 action. If the statute so provides, a condition precedent may be the commissioner's failure to
344 take a specific action.
345 (45) "Degree of relationship" means the number of steps between two persons
346 determined by counting the generations separating one person from a common ancestor and
347 then counting the generations to the other person.
348 (46) "Department" means the Insurance Department.
349 (47) "Director" means a member of the board of directors of a corporation.
350 (48) "Disability" means a physiological or psychological condition that partially or
351 totally limits an individual's ability to:
352 (a) perform the duties of:
353 (i) that individual's occupation; or
354 (ii) an occupation for which the individual is reasonably suited by education, training,
355 or experience; or
356 (b) perform two or more of the following basic activities of daily living:
357 (i) eating;
358 (ii) toileting;
359 (iii) transferring;
360 (iv) bathing; or
361 (v) dressing.
362 (49) "Disability income insurance" means the same as that term is defined in
363 Subsection [~~(82)~~] (83).
364 (50) "Domestic insurer" means an insurer organized under the laws of this state.
365 (51) "Domiciliary state" means the state in which an insurer:
366 (a) is incorporated;

367 (b) is organized; or
368 (c) in the case of an alien insurer, enters into the United States.
369 (52) (a) "Eligible employee" means:
370 (i) an employee who:
371 (A) works on a full-time basis; and
372 (B) has a normal work week of 30 or more hours; or
373 (ii) a person described in Subsection (52)(b).
374 (b) "Eligible employee" includes:
375 (i) an owner who:
376 (A) works on a full-time basis; and
377 (B) has a normal work week of 30 or more hours; and
378 (ii) if the individual is included under a health benefit plan of a small employer:
379 (A) a sole proprietor;
380 (B) a partner in a partnership; or
381 (C) an independent contractor.
382 (c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):
383 (i) an individual who works on a temporary or substitute basis for a small employer;
384 (ii) an employer's spouse who does not meet the requirements of Subsection (52)(a)(i);
385 or
386 (iii) a dependent of an employer who does not meet the requirements of Subsection
387 (52)(a)(i).
388 (53) "Employee" means:
389 (a) an individual employed by an employer; and
390 (b) an owner who meets the requirements of Subsection (52)(b)(i).
391 (54) "Employee benefits" means one or more benefits or services provided to:
392 (a) an employee; or
393 (b) a dependent of an employee.
394 (55) (a) "Employee welfare fund" means a fund:
395 (i) established or maintained, whether directly or through a trustee, by:
396 (A) one or more employers;
397 (B) one or more labor organizations; or

398 (C) a combination of employers and labor organizations; and
399 (ii) that provides employee benefits paid or contracted to be paid, other than income
400 from investments of the fund:
401 (A) by or on behalf of an employer doing business in this state; or
402 (B) for the benefit of a person employed in this state.
403 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
404 revenues.
405 (56) "Endorsement" means a written agreement attached to a policy or certificate to
406 modify the policy or certificate coverage.
407 (57) (a) "Enrollee" means:
408 (i) a policyholder;
409 (ii) a certificate holder;
410 (iii) a subscriber; or
411 (iv) a covered individual:
412 (A) who has entered into a contract with an organization for health care; or
413 (B) on whose behalf an arrangement for health care has been made.
414 (b) "Enrollee" includes an insured.
415 (58) "Enrollment date," with respect to a health benefit plan, means:
416 (a) the first day of coverage; or
417 (b) if there is a waiting period, the first day of the waiting period.
418 (59) "Enterprise risk" means an activity, circumstance, event, or series of events
419 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
420 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
421 holding company system as a whole, including anything that would cause:
422 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
423 Sections 31A-17-601 through 31A-17-613; or
424 (b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.
425 (60) (a) "Escrow" means:
426 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
427 when a person not a party to the transaction, and neither having nor acquiring an interest in the
428 title, performs, in accordance with the written instructions or terms of the written agreement

429 between the parties to the transaction, any of the following actions:
430 (A) the explanation, holding, or creation of a document; or
431 (B) the receipt, deposit, and disbursement of money;
432 (ii) a settlement or closing involving:
433 (A) a mobile home;
434 (B) a grazing right;
435 (C) a water right; or
436 (D) other personal property authorized by the commissioner.
437 (b) "Escrow" does not include:
438 (i) the following notarial acts performed by a notary within the state:
439 (A) an acknowledgment;
440 (B) a copy certification;
441 (C) jurat; and
442 (D) an oath or affirmation;
443 (ii) the receipt or delivery of a document; or
444 (iii) the receipt of money for delivery to the escrow agent.
445 (61) "Escrow agent" means an agency title insurance producer meeting the
446 requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an
447 individual title insurance producer licensed with an escrow subline of authority.
448 (62) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
449 excluded.
450 (b) The items listed in a list using the term "excludes" are representative examples for
451 use in interpretation of this title.
452 (63) "Exclusion" means for the purposes of accident and health insurance that an
453 insurer does not provide insurance coverage, for whatever reason, for one of the following:
454 (a) a specific physical condition;
455 (b) a specific medical procedure;
456 (c) a specific disease or disorder; or
457 (d) a specific prescription drug or class of prescription drugs.
458 (64) "Expense reimbursement insurance" means insurance:
459 (a) written to provide a payment for an expense relating to hospital confinement

460 resulting from illness or injury; and
461 (b) written:
462 (i) as a daily limit for a specific number of days in a hospital; and
463 (ii) to have a one or two day waiting period following a hospitalization.
464 (65) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding
465 a position of public or private trust.
466 (66) (a) "Filed" means that a filing is:
467 (i) submitted to the department as required by and in accordance with applicable
468 statute, rule, or filing order;
469 (ii) received by the department within the time period provided in applicable statute,
470 rule, or filing order; and
471 (iii) accompanied by the appropriate fee in accordance with:
472 (A) Section 31A-3-103; or
473 (B) rule.
474 (b) "Filed" does not include a filing that is rejected by the department because it is not
475 submitted in accordance with Subsection (66)(a).
476 (67) "Filing," when used as a noun, means an item required to be filed with the
477 department including:
478 (a) a policy;
479 (b) a rate;
480 (c) a form;
481 (d) a document;
482 (e) a plan;
483 (f) a manual;
484 (g) an application;
485 (h) a report;
486 (i) a certificate;
487 (j) an endorsement;
488 (k) an actuarial certification;
489 (l) a licensee annual statement;
490 (m) a licensee renewal application;

491 (n) an advertisement;
492 (o) a binder; or
493 (p) an outline of coverage.
494 (68) "First party insurance" means an insurance policy or contract in which the insurer
495 agrees to pay a claim submitted to it by the insured for the insured's losses.
496 (69) "Foreign insurer" means an insurer domiciled outside of this state, including an
497 alien insurer.
498 (70) (a) "Form" means one of the following prepared for general use:
499 (i) a policy;
500 (ii) a certificate;
501 (iii) an application;
502 (iv) an outline of coverage; or
503 (v) an endorsement.
504 (b) "Form" does not include a document specially prepared for use in an individual
505 case.
506 (71) "Franchise insurance" means an individual insurance policy provided through a
507 mass marketing arrangement involving a defined class of persons related in some way other
508 than through the purchase of insurance.
509 (72) "General lines of authority" include:
510 (a) the general lines of insurance in Subsection (73);
511 (b) title insurance under one of the following sublines of authority:
512 (i) title examination, including authority to act as a title marketing representative;
513 (ii) escrow, including authority to act as a title marketing representative; and
514 (iii) title marketing representative only;
515 (c) surplus lines;
516 (d) workers' compensation; and
517 (e) another line of insurance that the commissioner considers necessary to recognize in
518 the public interest.
519 (73) "General lines of insurance" include:
520 (a) accident and health;
521 (b) casualty;

522 (c) life;
523 (d) personal lines;
524 (e) property; and
525 (f) variable contracts, including variable life and annuity.
526 (74) "Group health plan" means an employee welfare benefit plan to the extent that the
527 plan provides medical care:
528 (a) (i) to an employee; or
529 (ii) to a dependent of an employee; and
530 (b) (i) directly;
531 (ii) through insurance reimbursement; or
532 (iii) through another method.
533 (75) (a) "Group insurance policy" means a policy covering a group of persons that is
534 issued:
535 (i) to a policyholder on behalf of the group; and
536 (ii) for the benefit of a member of the group who is selected under a procedure defined
537 in:
538 (A) the policy; or
539 (B) an agreement that is collateral to the policy.
540 (b) A group insurance policy may include a member of the policyholder's family or a
541 dependent.
542 (76) "Guaranteed automobile protection insurance" means insurance offered in
543 connection with an extension of credit that pays the difference in amount between the
544 insurance settlement and the balance of the loan if the insured automobile is a total loss.
545 (77) (a) "Health benefit plan" means, except as provided in Subsection (77)(b), a
546 policy, contract, certificate, or agreement offered or issued by a health carrier to provide,
547 deliver, arrange for, pay for, or reimburse any of the costs of health care.
548 (b) "Health benefit plan" does not include:
549 (i) coverage only for accident or disability income insurance, or any combination
550 thereof;
551 (ii) coverage issued as a supplement to liability insurance;
552 (iii) liability insurance, including general liability insurance and automobile liability

553 insurance;
554 (iv) workers' compensation or similar insurance;
555 (v) automobile medical payment insurance;
556 (vi) credit-only insurance;
557 (vii) coverage for on-site medical clinics;
558 (viii) other similar insurance coverage, specified in federal regulations issued pursuant
559 to Pub. L. No. 104-191, under which benefits for health care services are secondary or
560 incidental to other insurance benefits;
561 (ix) the following benefits if they are provided under a separate policy, certificate, or
562 contract of insurance or are otherwise not an integral part of the plan:
563 (A) limited scope dental or vision benefits;
564 (B) benefits for long-term care, nursing home care, home health care,
565 community-based care, or any combination thereof; or
566 (C) other similar limited benefits, specified in federal regulations issued pursuant to
567 Pub. L. No. 104-191;
568 (x) the following benefits if the benefits are provided under a separate policy,
569 certificate, or contract of insurance, there is no coordination between the provision of benefits
570 and any exclusion of benefits under any health plan, and the benefits are paid with respect to an
571 event without regard to whether benefits are provided under any health plan:
572 (A) coverage only for specified disease or illness; or
573 (B) hospital indemnity or other fixed indemnity insurance; and
574 (xi) the following if offered as a separate policy, certificate, or contract of insurance:
575 (A) Medicare supplemental health insurance as defined under the Social Security Act,
576 42 U.S.C. Sec. 1395ss(g)(1);
577 (B) coverage supplemental to the coverage provided under United States Code, Title
578 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services
579 (CHAMPUS); or
580 (C) similar supplemental coverage provided to coverage under a group health insurance
581 plan.
582 (78) "Health care" means any of the following intended for use in the diagnosis,
583 treatment, mitigation, or prevention of a human ailment or impairment:

584 (a) a professional service;
585 (b) a personal service;
586 (c) a facility;
587 (d) equipment;
588 (e) a device;
589 (f) supplies; or
590 (g) medicine.
591 (79) (a) "Health care insurance" or "health insurance" means insurance providing:
592 (i) a health care benefit; or
593 (ii) payment of an incurred health care expense.
594 (b) "Health care insurance" or "health insurance" does not include accident and health
595 insurance providing a benefit for:
596 (i) replacement of income;
597 (ii) short-term accident;
598 (iii) fixed indemnity;
599 (iv) credit accident and health;
600 (v) supplements to liability;
601 (vi) workers' compensation;
602 (vii) automobile medical payment;
603 (viii) no-fault automobile;
604 (ix) equivalent self-insurance; or
605 (x) a type of accident and health insurance coverage that is a part of or attached to
606 another type of policy.
607 (80) "Health care provider" means the same as that term is defined in Section
608 78B-3-403.
609 (81) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.
610 155.20.
611 [~~(81)~~] (82) "Health Insurance Portability and Accountability Act" means the Health
612 Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as
613 amended.
614 [~~(82)~~] (83) "Income replacement insurance" or "disability income insurance" means

615 insurance written to provide payments to replace income lost from accident or sickness.
616 [(83)] (84) "Indemnity" means the payment of an amount to offset all or part of an
617 insured loss.
618 [(84)] (85) "Independent adjuster" means an insurance adjuster required to be licensed
619 under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.
620 [(85)] (86) "Independently procured insurance" means insurance procured under
621 Section 31A-15-104.
622 [(86)] (87) "Individual" means a natural person.
623 [(87)] (88) "Inland marine insurance" includes insurance covering:
624 (a) property in transit on or over land;
625 (b) property in transit over water by means other than boat or ship;
626 (c) bailee liability;
627 (d) fixed transportation property such as bridges, electric transmission systems, radio
628 and television transmission towers and tunnels; and
629 (e) personal and commercial property floaters.
630 [(88)] (89) "Insolvency" or "insolvent" means that:
631 (a) an insurer is unable to pay [its debts or meet its obligations as the debts and
632 obligations mature] the insurer's obligations as the obligations are due;
633 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level
634 RBC under Subsection 31A-17-601(8)(c); or
635 (c) an [insurer is determined to be hazardous under this title] insurer's admitted assets
636 are less than the insurer's liabilities.
637 [(89)] (90) (a) "Insurance" means:
638 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
639 persons to one or more other persons; or
640 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a
641 group of persons that includes the person seeking to distribute that person's risk.
642 (b) "Insurance" includes:
643 (i) a risk distributing arrangement providing for compensation or replacement for
644 damages or loss through the provision of a service or a benefit in kind;
645 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a

646 business and not as merely incidental to a business transaction; and
647 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,
648 but with a class of persons who have agreed to share the risk.
649 [~~(90)~~] (91) "Insurance adjuster" means a person who directs or conducts the
650 investigation, negotiation, or settlement of a claim under an insurance policy other than life
651 insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance
652 policy.
653 [~~(91)~~] (92) "Insurance business" or "business of insurance" includes:
654 (a) providing health care insurance by an organization that is or is required to be
655 licensed under this title;
656 (b) providing a benefit to an employee in the event of a contingency not within the
657 control of the employee, in which the employee is entitled to the benefit as a right, which
658 benefit may be provided either:
659 (i) by a single employer or by multiple employer groups; or
660 (ii) through one or more trusts, associations, or other entities;
661 (c) providing an annuity:
662 (i) including an annuity issued in return for a gift; and
663 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
664 and (3);
665 (d) providing the characteristic services of a motor club as outlined in Subsection
666 [~~(120)~~] (121);
667 (e) providing another person with insurance;
668 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
669 or surety, a contract or policy of title insurance;
670 (g) transacting or proposing to transact any phase of title insurance, including:
671 (i) solicitation;
672 (ii) negotiation preliminary to execution;
673 (iii) execution of a contract of title insurance;
674 (iv) insuring; and
675 (v) transacting matters subsequent to the execution of the contract and arising out of
676 the contract, including reinsurance;

677 (h) transacting or proposing a life settlement; and
678 (i) doing, or proposing to do, any business in substance equivalent to Subsections
679 [(91)] (92)(a) through (h) in a manner designed to evade this title.
680 [(92)] (93) "Insurance consultant" or "consultant" means a person who:
681 (a) advises another person about insurance needs and coverages;
682 (b) is compensated by the person advised on a basis not directly related to the insurance
683 placed; and
684 (c) except as provided in Section 31A-23a-501, is not compensated directly or
685 indirectly by an insurer or producer for advice given.
686 [(93)] (94) "Insurance holding company system" means a group of two or more
687 affiliated persons, at least one of whom is an insurer.
688 [(94)] (95) (a) "Insurance producer" or "producer" means a person licensed or required
689 to be licensed under the laws of this state to sell, solicit, or negotiate insurance.
690 (b) (i) "Producer for the insurer" means a producer who is compensated directly or
691 indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that
692 insurer.
693 (ii) "Producer for the insurer" may be referred to as an "agent."
694 (c) (i) "Producer for the insured" means a producer who:
695 (A) is compensated directly and only by an insurance customer or an insured; and
696 (B) receives no compensation directly or indirectly from an insurer for selling,
697 soliciting, or negotiating an insurance product of that insurer to an insurance customer or
698 insured.
699 (ii) "Producer for the insured" may be referred to as a "broker."
700 [(95)] (96) (a) "Insured" means a person to whom or for whose benefit an insurer
701 makes a promise in an insurance policy and includes:
702 (i) a policyholder;
703 (ii) a subscriber;
704 (iii) a member; and
705 (iv) a beneficiary.
706 (b) The definition in Subsection [(95)] (96)(a):
707 (i) applies only to this title;

708 (ii) does not define the meaning of "insured" as used in an insurance policy or
709 certificate; and
710 (iii) includes an enrollee.
711 [(96)] (97) (a) "Insurer" means a person doing an insurance business as a principal
712 including:
713 (i) a fraternal benefit society;
714 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
715 31A-22-1305(2) and (3);
716 (iii) a motor club;
717 (iv) an employee welfare plan;
718 (v) a person purporting or intending to do an insurance business as a principal on that
719 person's own account; and
720 (vi) a health maintenance organization.
721 (b) "Insurer" does not include a governmental entity to the extent the governmental
722 entity is engaged in an activity described in Section 31A-12-107.
723 [(97)] (98) "Interinsurance exchange" means the same as that term is defined in
724 Subsection [(152)] (153).
725 [(98)] (99) "Involuntary unemployment insurance" means insurance:
726 (a) offered in connection with an extension of credit; and
727 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
728 coming due on a:
729 (i) specific loan; or
730 (ii) credit transaction.
731 [(99)] (100) (a) "Large employer," in connection with a health benefit plan, means an
732 employer who, with respect to a calendar year and to a plan year:
733 (i) employed an average of at least 51 employees on business days during the preceding
734 calendar year; and
735 (ii) employs at least one employee on the first day of the plan year.
736 (b) The number of employees shall be determined using the method set forth in 26
737 U.S.C. Sec. 4980H(c)(2).
738 [(100)] (101) "Late enrollee," with respect to an employer health benefit plan, means

739 an individual whose enrollment is a late enrollment.
740 [~~(101)~~] (102) "Late enrollment," with respect to an employer health benefit plan, means
741 enrollment of an individual other than:
742 (a) on the earliest date on which coverage can become effective for the individual
743 under the terms of the plan; or
744 (b) through special enrollment.
745 [~~(102)~~] (103) (a) Except for a retainer contract or legal assistance described in Section
746 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a
747 specified legal expense.
748 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
749 expectation of an enforceable right.
750 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
751 legal services incidental to other insurance coverage.
752 [~~(103)~~] (104) (a) "Liability insurance" means insurance against liability:
753 (i) for death, injury, or disability of a human being, or for damage to property,
754 exclusive of the coverages under:
755 (A) medical malpractice insurance;
756 (B) professional liability insurance; and
757 (C) workers' compensation insurance;
758 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
759 insured who is injured, irrespective of legal liability of the insured, when issued with or
760 supplemental to insurance against legal liability for the death, injury, or disability of a human
761 being, exclusive of the coverages under:
762 (A) medical malpractice insurance;
763 (B) professional liability insurance; and
764 (C) workers' compensation insurance;
765 (iii) for loss or damage to property resulting from an accident to or explosion of a
766 boiler, pipe, pressure container, machinery, or apparatus;
767 (iv) for loss or damage to property caused by:
768 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
769 (B) water entering through a leak or opening in a building; or

770 (v) for other loss or damage properly the subject of insurance not within another kind
771 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
772 (b) "Liability insurance" includes:
773 (i) vehicle liability insurance;
774 (ii) residential dwelling liability insurance; and
775 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
776 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
777 elevator, boiler, machinery, or apparatus.
778 [~~(104)~~] (105) (a) "License" means authorization issued by the commissioner to engage
779 in an activity that is part of or related to the insurance business.
780 (b) "License" includes a certificate of authority issued to an insurer.
781 [~~(105)~~] (106) (a) "Life insurance" means:
782 (i) insurance on a human life; and
783 (ii) insurance pertaining to or connected with human life.
784 (b) The business of life insurance includes:
785 (i) granting a death benefit;
786 (ii) granting an annuity benefit;
787 (iii) granting an endowment benefit;
788 (iv) granting an additional benefit in the event of death by accident;
789 (v) granting an additional benefit to safeguard the policy against lapse; and
790 (vi) providing an optional method of settlement of proceeds.
791 [~~(106)~~] (107) "Limited license" means a license that:
792 (a) is issued for a specific product of insurance; and
793 (b) limits an individual or agency to transact only for that product or insurance.
794 [~~(107)~~] (108) "Limited line credit insurance" includes the following forms of
795 insurance:
796 (a) credit life;
797 (b) credit accident and health;
798 (c) credit property;
799 (d) credit unemployment;
800 (e) involuntary unemployment;

801 (f) mortgage life;
802 (g) mortgage guaranty;
803 (h) mortgage accident and health;
804 (i) guaranteed automobile protection; and
805 (j) another form of insurance offered in connection with an extension of credit that:
806 (i) is limited to partially or wholly extinguishing the credit obligation; and
807 (ii) the commissioner determines by rule should be designated as a form of limited line
808 credit insurance.
809 [~~(108)~~] (109) "Limited line credit insurance producer" means a person who sells,
810 solicits, or negotiates one or more forms of limited line credit insurance coverage to an
811 individual through a master, corporate, group, or individual policy.
812 [~~(109)~~] (110) "Limited line insurance" includes:
813 (a) bail bond;
814 (b) limited line credit insurance;
815 (c) legal expense insurance;
816 (d) motor club insurance;
817 (e) car rental related insurance;
818 (f) travel insurance;
819 (g) crop insurance;
820 (h) self-service storage insurance;
821 (i) guaranteed asset protection waiver;
822 (j) portable electronics insurance; and
823 (k) another form of limited insurance that the commissioner determines by rule should
824 be designated a form of limited line insurance.
825 [~~(110)~~] (111) "Limited lines authority" includes the lines of insurance listed in
826 Subsection [~~(109)~~] (110).
827 [~~(111)~~] (112) "Limited lines producer" means a person who sells, solicits, or negotiates
828 limited lines insurance.
829 [~~(112)~~] (113) (a) "Long-term care insurance" means an insurance policy or rider
830 advertised, marketed, offered, or designated to provide coverage:
831 (i) in a setting other than an acute care unit of a hospital;

832 (ii) for not less than 12 consecutive months for a covered person on the basis of:
833 (A) expenses incurred;
834 (B) indemnity;
835 (C) prepayment; or
836 (D) another method;
837 (iii) for one or more necessary or medically necessary services that are:
838 (A) diagnostic;
839 (B) preventative;
840 (C) therapeutic;
841 (D) rehabilitative;
842 (E) maintenance; or
843 (F) personal care; and
844 (iv) that may be issued by:
845 (A) an insurer;
846 (B) a fraternal benefit society;
847 (C) (I) a nonprofit health hospital; and
848 (II) a medical service corporation;
849 (D) a prepaid health plan;
850 (E) a health maintenance organization; or
851 (F) an entity similar to the entities described in Subsections [~~(112)~~] (113)(a)(iv)(A)
852 through (E) to the extent that the entity is otherwise authorized to issue life or health care
853 insurance.
854 (b) "Long-term care insurance" includes:
855 (i) any of the following that provide directly or supplement long-term care insurance:
856 (A) a group or individual annuity or rider; or
857 (B) a life insurance policy or rider;
858 (ii) a policy or rider that provides for payment of benefits on the basis of:
859 (A) cognitive impairment; or
860 (B) functional capacity; or
861 (iii) a qualified long-term care insurance contract.
862 (c) "Long-term care insurance" does not include:

863 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
864 (ii) basic hospital expense coverage;
865 (iii) basic medical/surgical expense coverage;
866 (iv) hospital confinement indemnity coverage;
867 (v) major medical expense coverage;
868 (vi) income replacement or related asset-protection coverage;
869 (vii) accident only coverage;
870 (viii) coverage for a specified:
871 (A) disease; or
872 (B) accident;
873 (ix) limited benefit health coverage; or
874 (x) a life insurance policy that accelerates the death benefit to provide the option of a
875 lump sum payment:
876 (A) if the following are not conditioned on the receipt of long-term care:
877 (I) benefits; or
878 (II) eligibility; and
879 (B) the coverage is for one or more the following qualifying events:
880 (I) terminal illness;
881 (II) medical conditions requiring extraordinary medical intervention; or
882 (III) permanent institutional confinement.
883 [~~(113)~~] (114) "Managed care organization" means a person:
884 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
885 Organizations and Limited Health Plans; or
886 (b) (i) licensed under:
887 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
888 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
889 (C) Chapter 14, Foreign Insurers; and
890 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
891 for an enrollee to use, network providers.
892 [~~(114)~~] (115) "Medical malpractice insurance" means insurance against legal liability
893 incident to the practice and provision of a medical service other than the practice and provision

894 of a dental service.
895 [~~(115)~~] (116) "Member" means a person having membership rights in an insurance
896 corporation.
897 [~~(116)~~] (117) "Minimum capital" or "minimum required capital" means the capital that
898 must be constantly maintained by a stock insurance corporation as required by statute.
899 [~~(117)~~] (118) "Mortgage accident and health insurance" means insurance offered in
900 connection with an extension of credit that provides indemnity for payments coming due on a
901 mortgage while the debtor has a disability.
902 [~~(118)~~] (119) "Mortgage guaranty insurance" means surety insurance under which a
903 mortgagee or other creditor is indemnified against losses caused by the default of a debtor.
904 [~~(119)~~] (120) "Mortgage life insurance" means insurance on the life of a debtor in
905 connection with an extension of credit that pays if the debtor dies.
906 [~~(120)~~] (121) "Motor club" means a person:
907 (a) licensed under:
908 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
909 (ii) Chapter 11, Motor Clubs; or
910 (iii) Chapter 14, Foreign Insurers; and
911 (b) that promises for an advance consideration to provide for a stated period of time
912 one or more:
913 (i) legal services under Subsection 31A-11-102(1)(b);
914 (ii) bail services under Subsection 31A-11-102(1)(c); or
915 (iii) (A) trip reimbursement;
916 (B) towing services;
917 (C) emergency road services;
918 (D) stolen automobile services;
919 (E) a combination of the services listed in Subsections [~~(120)~~] (121)(b)(iii)(A) through
920 (D); or
921 (F) other services given in Subsections 31A-11-102(1)(b) through (f).
922 [~~(121)~~] (122) "Mutual" means a mutual insurance corporation.
923 [~~(122)~~] (123) "Network plan" means health care insurance:
924 (a) that is issued by an insurer; and

925 (b) under which the financing and delivery of medical care is provided, in whole or in
926 part, through a defined set of providers under contract with the insurer, including the financing
927 and delivery of an item paid for as medical care.
928 [~~(123)~~] (124) "Network provider" means a health care provider who has an agreement
929 with a managed care organization to provide health care services to an enrollee with an
930 expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly
931 from the managed care organization.
932 [~~(124)~~] (125) "Nonparticipating" means a plan of insurance under which the insured is
933 not entitled to receive a dividend representing a share of the surplus of the insurer.
934 [~~(125)~~] (126) "Ocean marine insurance" means insurance against loss of or damage to:
935 (a) ships or hulls of ships;
936 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
937 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
938 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
939 (c) earnings such as freight, passage money, commissions, or profits derived from
940 transporting goods or people upon or across the oceans or inland waterways; or
941 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
942 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
943 in connection with maritime activity.
944 [~~(126)~~] (127) "Order" means an order of the commissioner.
945 [~~(127)~~] (128) "Outline of coverage" means a summary that explains an accident and
946 health insurance policy.
947 [~~(128)~~] (129) "Participating" means a plan of insurance under which the insured is
948 entitled to receive a dividend representing a share of the surplus of the insurer.
949 [~~(129)~~] (130) "Participation," as used in a health benefit plan, means a requirement
950 relating to the minimum percentage of eligible employees that must be enrolled in relation to
951 the total number of eligible employees of an employer reduced by each eligible employee who
952 voluntarily declines coverage under the plan because the employee:
953 (a) has other group health care insurance coverage; or
954 (b) receives:
955 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social

956 Security Amendments of 1965; or

957 (ii) another government health benefit.

958 [~~(130)~~] (131) "Person" includes:

959 (a) an individual;

960 (b) a partnership;

961 (c) a corporation;

962 (d) an incorporated or unincorporated association;

963 (e) a joint stock company;

964 (f) a trust;

965 (g) a limited liability company;

966 (h) a reciprocal;

967 (i) a syndicate; or

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

969 [~~(131)~~] (132) "Personal lines insurance" means property and casualty insurance

970 coverage sold for primarily noncommercial purposes to:

971 (a) an individual; or

972 (b) a family.

973 [~~(132)~~] (133) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.

974 1002(16)(B).

975 [~~(133)~~] (134) "Plan year" means:

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

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

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

979 (b) if the plan document or summary plan description does not designate a plan year or

980 there is no plan document or summary plan description:

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

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

983 or

984 (iii) the employer's taxable year if:

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

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

987 (II) the insurance policy is not renewed on an annual basis; or
988 (c) in a case not described in Subsection [~~(133)~~] (134)(a) or (b), the calendar year.
989 [~~(134)~~] (135) (a) "Policy" means a document, including an attached endorsement or
990 application that:
991 (i) purports to be an enforceable contract; and
992 (ii) memorializes in writing some or all of the terms of an insurance contract.
993 (b) "Policy" includes a service contract issued by:
994 (i) a motor club under Chapter 11, Motor Clubs;
995 (ii) a service contract provided under Chapter 6a, Service Contracts; and
996 (iii) a corporation licensed under:
997 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
998 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
999 (c) "Policy" does not include:
1000 (i) a certificate under a group insurance contract; or
1001 (ii) a document that does not purport to have legal effect.
1002 [~~(135)~~] (136) "Policyholder" means a person who controls a policy, binder, or oral
1003 contract by ownership, premium payment, or otherwise.
1004 [~~(136)~~] (137) "Policy illustration" means a presentation or depiction that includes
1005 nonguaranteed elements of a policy of life insurance over a period of years.
1006 [~~(137)~~] (138) "Policy summary" means a synopsis describing the elements of a life
1007 insurance policy.
1008 [~~(138)~~] (139) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L.
1009 No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152,
1010 and related federal regulations and guidance.
1011 [~~(139)~~] (140) "Preexisting condition," with respect to [~~a health benefit plan~~] health care
1012 insurance:
1013 (a) means a condition that was present before the effective date of coverage, whether or
1014 not medical advice, diagnosis, care, or treatment was recommended or received before that day;
1015 and
1016 (b) does not include a condition indicated by genetic information unless an actual
1017 diagnosis of the condition by a physician has been made.

1018 [(140)] (141) (a) "Premium" means the monetary consideration for an insurance policy.
1019 (b) "Premium" includes, however designated:
1020 (i) an assessment;
1021 (ii) a membership fee;
1022 (iii) a required contribution; or
1023 (iv) monetary consideration.
1024 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1025 the third party administrator's services.
1026 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1027 insurance on the risks administered by the third party administrator.
1028 [(141)] (142) "Principal officers" for a corporation means the officers designated under
1029 Subsection 31A-5-203(3).
1030 [(142)] (143) "Proceeding" includes an action or special statutory proceeding.
1031 [(143)] (144) "Professional liability insurance" means insurance against legal liability
1032 incident to the practice of a profession and provision of a professional service.
1033 [(144)] (145) (a) Except as provided in Subsection [(144)] (145)(b), "property
1034 insurance" means insurance against loss or damage to real or personal property of every kind
1035 and any interest in that property:
1036 (i) from all hazards or causes; and
1037 (ii) against loss consequential upon the loss or damage including vehicle
1038 comprehensive and vehicle physical damage coverages.
1039 (b) "Property insurance" does not include:
1040 (i) inland marine insurance; and
1041 (ii) ocean marine insurance.
1042 [(145)] (146) "Qualified long-term care insurance contract" or "federally tax qualified
1043 long-term care insurance contract" means:
1044 (a) an individual or group insurance contract that meets the requirements of Section
1045 7702B(b), Internal Revenue Code; or
1046 (b) the portion of a life insurance contract that provides long-term care insurance:
1047 (i) (A) by rider; or
1048 (B) as a part of the contract; and

1049 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1050 Code.
1051 [(146)] (147) "Qualified United States financial institution" means an institution that:
1052 (a) is:
1053 (i) organized under the laws of the United States or any state; or
1054 (ii) in the case of a United States office of a foreign banking organization, licensed
1055 under the laws of the United States or any state;
1056 (b) is regulated, supervised, and examined by a United States federal or state authority
1057 having regulatory authority over a bank or trust company; and
1058 (c) meets the standards of financial condition and standing that are considered
1059 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1060 will be acceptable to the commissioner as determined by:
1061 (i) the commissioner by rule; or
1062 (ii) the Securities Valuation Office of the National Association of Insurance
1063 Commissioners.
1064 [(147)] (148) (a) "Rate" means:
1065 (i) the cost of a given unit of insurance; or
1066 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1067 expressed as:
1068 (A) a single number; or
1069 (B) a pure premium rate, adjusted before the application of individual risk variations
1070 based on loss or expense considerations to account for the treatment of:
1071 (I) expenses;
1072 (II) profit; and
1073 (III) individual insurer variation in loss experience.
1074 (b) "Rate" does not include a minimum premium.
1075 [(148)] (149) (a) Except as provided in Subsection [(148)] (149)(b), "rate service
1076 organization" means a person who assists an insurer in rate making or filing by:
1077 (i) collecting, compiling, and furnishing loss or expense statistics;
1078 (ii) recommending, making, or filing rates or supplementary rate information; or
1079 (iii) advising about rate questions, except as an attorney giving legal advice.

1080 (b) "Rate service organization" does not mean:
1081 (i) an employee of an insurer;
1082 (ii) a single insurer or group of insurers under common control;
1083 (iii) a joint underwriting group; or
1084 (iv) an individual serving as an actuarial or legal consultant.
1085 [~~(149)~~] (150) "Rating manual" means any of the following used to determine initial and
1086 renewal policy premiums:
1087 (a) a manual of rates;
1088 (b) a classification;
1089 (c) a rate-related underwriting rule; and
1090 (d) a rating formula that describes steps, policies, and procedures for determining
1091 initial and renewal policy premiums.
1092 [~~(150)~~] (151) (a) "Rebate" means a licensee paying, allowing, giving, or offering to
1093 pay, allow, or give, directly or indirectly:
1094 (i) a refund of premium or portion of premium;
1095 (ii) a refund of commission or portion of commission;
1096 (iii) a refund of all or a portion of a consultant fee; or
1097 (iv) providing services or other benefits not specified in an insurance or annuity
1098 contract.
1099 (b) "Rebate" does not include:
1100 (i) a refund due to termination or changes in coverage;
1101 (ii) a refund due to overcharges made in error by the licensee; or
1102 (iii) savings or wellness benefits as provided in the contract by the licensee.
1103 [~~(151)~~] (152) "Received by the department" means:
1104 (a) the date delivered to and stamped received by the department, if delivered in
1105 person;
1106 (b) the post mark date, if delivered by mail;
1107 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
1108 (d) the received date recorded on an item delivered, if delivered by:
1109 (i) facsimile;
1110 (ii) email; or

1111 (iii) another electronic method; or
1112 (e) a date specified in:
1113 (i) a statute;
1114 (ii) a rule; or
1115 (iii) an order.
1116 [~~(152)~~] (153) "Reciprocal" or "interinsurance exchange" means an unincorporated
1117 association of persons:
1118 (a) operating through an attorney-in-fact common to all of the persons; and
1119 (b) exchanging insurance contracts with one another that provide insurance coverage
1120 on each other.
1121 [~~(153)~~] (154) "Reinsurance" means an insurance transaction where an insurer, for
1122 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1123 reinsurance transactions, this title sometimes refers to:
1124 (a) the insurer transferring the risk as the "ceding insurer"; and
1125 (b) the insurer assuming the risk as the:
1126 (i) "assuming insurer"; or
1127 (ii) "assuming reinsurer."
1128 [~~(154)~~] (155) "Reinsurer" means a person licensed in this state as an insurer with the
1129 authority to assume reinsurance.
1130 [~~(155)~~] (156) "Residential dwelling liability insurance" means insurance against
1131 liability resulting from or incident to the ownership, maintenance, or use of a residential
1132 dwelling that is a detached single family residence or multifamily residence up to four units.
1133 [~~(156)~~] (157) (a) "Retrocession" means reinsurance with another insurer of a liability
1134 assumed under a reinsurance contract.
1135 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a
1136 liability assumed under a reinsurance contract.
1137 [~~(157)~~] (158) "Rider" means an endorsement to:
1138 (a) an insurance policy; or
1139 (b) an insurance certificate.
1140 [~~(158)~~] (159) "Secondary medical condition" means a complication related to an
1141 exclusion from coverage in accident and health insurance.

1142 [~~(159)~~] (160) (a) "Security" means a:
1143 (i) note;
1144 (ii) stock;
1145 (iii) bond;
1146 (iv) debenture;
1147 (v) evidence of indebtedness;
1148 (vi) certificate of interest or participation in a profit-sharing agreement;
1149 (vii) collateral-trust certificate;
1150 (viii) preorganization certificate or subscription;
1151 (ix) transferable share;
1152 (x) investment contract;
1153 (xi) voting trust certificate;
1154 (xii) certificate of deposit for a security;
1155 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1156 payments out of production under such a title or lease;
1157 (xiv) commodity contract or commodity option;
1158 (xv) certificate of interest or participation in, temporary or interim certificate for,
1159 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
1160 in Subsections [~~(159)~~] (160)(a)(i) through (xiv); or
1161 (xvi) another interest or instrument commonly known as a security.
1162 (b) "Security" does not include:
1163 (i) any of the following under which an insurance company promises to pay money in a
1164 specific lump sum or periodically for life or some other specified period:
1165 (A) insurance;
1166 (B) an endowment policy; or
1167 (C) an annuity contract; or
1168 (ii) a burial certificate or burial contract.
1169 [~~(160)~~] (161) "Securityholder" means a specified person who owns a security of a
1170 person, including:
1171 (a) common stock;
1172 (b) preferred stock;

1173 (c) debt obligations; and

1174 (d) any other security convertible into or evidencing the right of any of the items listed

1175 in this Subsection [~~(160)~~] (161).

1176 [~~(161)~~] (162) (a) "Self-insurance" means an arrangement under which a person

1177 provides for spreading its own risks by a systematic plan.

1178 (b) Except as provided in this Subsection [~~(161)~~] (162), "self-insurance" does not

1179 include an arrangement under which a number of persons spread their risks among themselves.

1180 (c) "Self-insurance" includes:

1181 (i) an arrangement by which a governmental entity undertakes to indemnify an

1182 employee for liability arising out of the employee's employment; and

1183 (ii) an arrangement by which a person with a managed program of self-insurance and

1184 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or

1185 employees for liability or risk that is related to the relationship or employment.

1186 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1187 [~~(162)~~] (163) "Sell" means to exchange a contract of insurance:

1188 (a) by any means;

1189 (b) for money or its equivalent; and

1190 (c) on behalf of an insurance company.

1191 [~~(163)~~] (164) "Short-term care insurance" means an insurance policy or rider

1192 advertised, marketed, offered, or designed to provide coverage that is similar to long-term care

1193 insurance, but that provides coverage for less than 12 consecutive months for each covered

1194 person.

1195 [~~(164)~~] (165) "Significant break in coverage" means a period of 63 consecutive days

1196 during each of which an individual does not have creditable coverage.

1197 [~~(165)~~] (166) (a) "Small employer" means, in connection with a health benefit plan and

1198 with respect to a calendar year and to a plan year, an employer who:

1199 (i) employed at least one employee but not more than 50 employees on business days

1200 during the preceding calendar year; and

1201 (ii) employs at least one employee on the first day of the plan year.

1202 (b) The number of employees shall:

1203 (i) be determined using the method set forth in 26 U.S.C. Sec. 4980H(c)(2); and

1204 (ii) include an owner described in Subsection (52)(b)(i).
1205 (c) "Small employer" does not include a sole proprietor that does not employ at least
1206 one employee.
1207 [~~(166)~~] <u>(167)</u> "Special enrollment period," in connection with a health benefit plan, has
1208 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1209 Portability and Accountability Act.
1210 [~~(167)~~] <u>(168)</u> (a) "Subsidiary" of a person means an affiliate controlled by that person
1211 either directly or indirectly through one or more affiliates or intermediaries.
1212 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1213 shares are owned by that person either alone or with its affiliates, except for the minimum
1214 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1215 others.
1216 [~~(168)~~] <u>(169)</u> Subject to Subsection [~~(89)~~] <u>(90)</u>(b), "surety insurance" includes:
1217 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1218 perform the principal's obligations to a creditor or other obligee;
1219 (b) bail bond insurance; and
1220 (c) fidelity insurance.
1221 [~~(169)~~] <u>(170)</u> (a) "Surplus" means the excess of assets over the sum of paid-in capital
1222 and liabilities.
1223 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1224 designated by the insurer or organization as permanent.
1225 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require
1226 that insurers or organizations doing business in this state maintain specified minimum levels of
1227 permanent surplus.
1228 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1229 same as the minimum required capital requirement that applies to stock insurers.
1230 (c) "Excess surplus" means:
1231 (i) for a life insurer, accident and health insurer, health organization, or property and
1232 casualty insurer as defined in Section 31A-17-601, the lesser of:
1233 (A) that amount of an insurer's or health organization's total adjusted capital that
1234 exceeds the product of:

1235 (I) 2.5; and
1236 (II) the sum of the insurer's or health organization's minimum capital or permanent
1237 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or
1238 (B) that amount of an insurer's or health organization's total adjusted capital that
1239 exceeds the product of:
1240 (I) 3.0; and
1241 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and
1242 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1243 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1244 (A) 1.5; and
1245 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1246 [~~(170)~~] (171) "Third party administrator" or "administrator" means a person who
1247 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1248 residents of the state in connection with insurance coverage, annuities, or service insurance
1249 coverage, except:
1250 (a) a union on behalf of its members;
1251 (b) a person administering a:
1252 (i) pension plan subject to the federal Employee Retirement Income Security Act of
1253 1974;
1254 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1255 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1256 (c) an employer on behalf of the employer's employees or the employees of one or
1257 more of the subsidiary or affiliated corporations of the employer;
1258 (d) an insurer licensed under the following, but only for a line of insurance for which
1259 the insurer holds a license in this state:
1260 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1261 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
1262 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1263 (iv) Chapter 9, Insurance Fraternals; or
1264 (v) Chapter 14, Foreign Insurers;
1265 (e) a person:

1266 (i) licensed or exempt from licensing under:
1267 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
1268 Reinsurance Intermediaries; or
1269 (B) Chapter 26, Insurance Adjusters; and
1270 (ii) whose activities are limited to those authorized under the license the person holds
1271 or for which the person is exempt; or
1272 (f) an institution, bank, or financial institution:
1273 (i) that is:
1274 (A) an institution whose deposits and accounts are to any extent insured by a federal
1275 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
1276 Credit Union Administration; or
1277 (B) a bank or other financial institution that is subject to supervision or examination by
1278 a federal or state banking authority; and
1279 (ii) that does not adjust claims without a third party administrator license.
1280 [~~(171)~~] (172) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1281 owner of real or personal property or the holder of liens or encumbrances on that property, or
1282 others interested in the property against loss or damage suffered by reason of liens or
1283 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1284 or unenforceability of any liens or encumbrances on the property.
1285 [~~(172)~~] (173) "Total adjusted capital" means the sum of an insurer's or health
1286 organization's statutory capital and surplus as determined in accordance with:
1287 (a) the statutory accounting applicable to the annual financial statements required to be
1288 filed under Section 31A-4-113; and
1289 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1290 Section 31A-17-601.
1291 [~~(173)~~] (174) (a) "Trustee" means "director" when referring to the board of directors of
1292 a corporation.
1293 (b) "Trustee," when used in reference to an employee welfare fund, means an
1294 individual, firm, association, organization, joint stock company, or corporation, whether acting
1295 individually or jointly and whether designated by that name or any other, that is charged with
1296 or has the overall management of an employee welfare fund.

1297 [(174)] (175) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1298 insurer" means an insurer:
1299 (i) not holding a valid certificate of authority to do an insurance business in this state;
1300 or
1301 (ii) transacting business not authorized by a valid certificate.
1302 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1303 (i) holding a valid certificate of authority to do an insurance business in this state; and
1304 (ii) transacting business as authorized by a valid certificate.
1305 [(175)] (176) "Underwrite" means the authority to accept or reject risk on behalf of the
1306 insurer.
1307 [(176)] (177) "Vehicle liability insurance" means insurance against liability resulting
1308 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
1309 vehicle comprehensive or vehicle physical damage coverage under Subsection [(144)] (145).
1310 [(177)] (178) "Voting security" means a security with voting rights, and includes a
1311 security convertible into a security with a voting right associated with the security.
1312 [(178)] (179) "Waiting period" for a health benefit plan means the period that must
1313 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
1314 the health benefit plan, can become effective.
1315 [(179)] (180) "Workers' compensation insurance" means:
1316 (a) insurance for indemnification of an employer against liability for compensation
1317 based on:
1318 (i) a compensable accidental injury; and
1319 (ii) occupational disease disability;
1320 (b) employer's liability insurance incidental to workers' compensation insurance and
1321 written in connection with workers' compensation insurance; and
1322 (c) insurance assuring to a person entitled to workers' compensation benefits the
1323 compensation provided by law.
1324 Section 2. Section **31A-2-201.1** is amended to read:
1325 **31A-2-201.1. General filing requirements.**
1326 Except as otherwise provided in this title, the commissioner may set by rule made in
1327 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific

1328 requirements for filing any of the following required by this title:
1329 (1) a form;
1330 (2) a rate; [~~or~~]
1331 (3) a report[~~.~~]; or
1332 (4) a binder for a health benefit plan or dental policy.
1333 Section 3. Section **31A-2-201.2** is amended to read:
1334 **31A-2-201.2. Evaluation of health insurance market.**
1335 (1) Each year the commissioner shall:
1336 (a) conduct an evaluation of the state's health insurance market;
1337 (b) report the findings of the evaluation to the Health and Human Services Interim
1338 Committee before [~~October~~] December 1 of each year; and
1339 (c) publish the findings of the evaluation on the department website.
1340 (2) The evaluation required by this section shall:
1341 (a) analyze the effectiveness of the insurance regulations and statutes in promoting a
1342 healthy, competitive health insurance market that meets the needs of the state, and includes an
1343 analysis of:
1344 (i) the availability and marketing of individual and group products;
1345 (ii) rate changes;
1346 (iii) coverage and demographic changes;
1347 (iv) benefit trends;
1348 (v) market share changes; and
1349 (vi) accessibility;
1350 (b) assess complaint ratios and trends within the health insurance market, which
1351 assessment shall include complaint data from the Office of Consumer Health Assistance within
1352 the department;
1353 (c) contain recommendations for action to improve the overall effectiveness of the
1354 health insurance market, administrative rules, and statutes; and
1355 (d) include claims loss ratio data for each health insurance company doing business in
1356 the state.
1357 (3) When preparing the evaluation and report required by this section, the
1358 commissioner may seek the input of insurers, employers, insured persons, providers, and others

1359 with an interest in the health insurance market.

1360 (4) The commissioner may adopt administrative rules for the purpose of collecting the

1361 data required by this section, taking into account the business confidentiality of the insurers.

1362 (5) Records submitted to the commissioner under this section shall be maintained by

1363 the commissioner as protected records under Title 63G, Chapter 2, Government Records

1364 Access and Management Act.

1365 Section 4. Section **31A-2-204** is amended to read:

1366 **31A-2-204. Conducting examinations.**

1367 (1) As used in this section, "work papers" means a record that is created or relied upon:

1368 (a) during the course of an examination conducted under Section 31A-2-203; or

1369 (b) in drafting an examination report.

1370 [(1)] (2) (a) For each examination under Section 31A-2-203, the commissioner shall

1371 issue an order:

1372 (i) stating the scope of the examination; and

1373 (ii) designating the examiner in charge.

1374 (b) The commissioner need not give advance notice of an examination to an examinee.

1375 (c) The examiner in charge shall give the examinee a copy of the order issued under

1376 this Subsection [(1)] (2).

1377 (d) (i) The commissioner may alter the scope or nature of an examination at any time

1378 without advance notice to the examinee.

1379 (ii) If the commissioner amends an order described in this Subsection [(1)] (2), the

1380 commissioner shall provide a copy of any amended order to the examinee.

1381 (e) Statements in the commissioner's examination order concerning examination scope

1382 are for the examiner's guidance only.

1383 (f) Examining relevant matters not mentioned in an order issued under this Subsection

1384 [(1)] (2) is not a violation of this title.

1385 [(2)] (3) The commissioner shall, whenever practicable, cooperate with the insurance

1386 regulators of other states by conducting joint examinations of:

1387 (a) multistate insurers doing business in this state; or

1388 (b) other multistate licensees doing business in this state.

1389 [(3)] (4) An examiner authorized by the commissioner shall, when necessary to the

1390 purposes of the examination, have access at all reasonable hours to the premises and to any
1391 books, records, files, securities, documents, or property of:
1392 (a) the examinee; and
1393 (b) any of the following if the premises, books, records, files, securities, documents, or
1394 property relate to the affairs of the examinee:
1395 (i) an officer of the examinee;
1396 (ii) any other person who:
1397 (A) has executive authority over the examinee; or
1398 (B) is in charge of any segment of the examinee's affairs; or
1399 (iii) any affiliate of the examinee under Subsection 31A-2-203(1)(b).
1400 [~~(4)~~] <u>(5)</u> (a) The officers, employees, and agents of the examinee and of persons under
1401 Subsection 31A-2-203(1)(b) shall comply with every reasonable request of the examiners for
1402 assistance in any matter relating to the examination.
1403 (b) A person may not obstruct or interfere with the examination except by legal
1404 process.
1405 [~~(5)~~] <u>(6)</u> If the commissioner finds the accounts or records to be inadequate for proper
1406 examination of the condition and affairs of the examinee or improperly kept or posted, the
1407 commissioner may employ experts to rewrite, post, or balance the accounts or records at the
1408 expense of the examinee.
1409 [~~(6)~~] <u>(7)</u> (a) The examiner in charge of an examination shall make a report of the
1410 examination no later than 60 days after the completion of the examination that shall include:
1411 (i) the information and analysis ordered under Subsection [~~(1)~~] <u>(2)</u>; and
1412 (ii) the examiner's recommendations.
1413 (b) At the option of the examiner in charge, preparation of the report may include
1414 conferences with the examinee or representatives of the examinee.
1415 (c) The report is confidential until the report becomes a public document under
1416 Subsection [~~(7)~~] <u>(8)</u>, except the commissioner may use information from the report as a basis
1417 for action under Chapter 27a, Insurer Receivership Act.
1418 [~~(7)~~] <u>(8)</u> (a) The commissioner shall serve a copy of the examination report described
1419 in Subsection [~~(6)~~] <u>(7)</u> upon the examinee.
1420 (b) Within 20 days after service, the examinee shall:

1421 (i) accept the examination report as written; or
1422 (ii) request agency action to modify the examination report.
1423 (c) The report is considered accepted under this Subsection [~~(7)~~] (8) if the examinee
1424 does not file a request for agency action to modify the report within 20 days after service of the
1425 report.
1426 (d) If the examination report is accepted:
1427 (i) the examination report immediately becomes a public document; and
1428 (ii) the commissioner shall distribute the examination report to all jurisdictions in
1429 which the examinee is authorized to do business.
1430 (e) (i) Any adjudicative proceeding held as a result of the examinee's request for
1431 agency action shall, upon the examinee's demand, be closed to the public, except that the
1432 commissioner need not exclude any participating examiner from this closed hearing.
1433 (ii) Within 20 days after the hearing held under this Subsection [~~(7)~~] (8)(e), the
1434 commissioner shall:
1435 (A) adopt the examination report with any necessary modifications; and
1436 (B) serve a copy of the adopted report upon the examinee.
1437 (iii) Unless the examinee seeks judicial relief, the adopted examination report:
1438 (A) shall become a public document 10 days after service; and
1439 (B) may be distributed as described in this section.
1440 (f) Notwithstanding Title 63G, Chapter 4, Administrative Procedures Act, to the extent
1441 that this section is in conflict with Title 63G, Chapter 4, Administrative Procedures Act, this
1442 section governs:
1443 (i) a request for agency action under this section; or
1444 (ii) adjudicative proceeding under this section.
1445 [~~(8)~~] (9) The examinee shall promptly furnish copies of the adopted examination report
1446 described in Subsection [~~(7)~~] (8) to each member of the examinee's board.
1447 [~~(9)~~] (10) After an examination report becomes a public document under Subsection
1448 [~~(7)~~] (8), the commissioner may furnish, without cost or at a reasonable price set under Section
1449 31A-3-103, a copy of the examination report to interested persons, including:
1450 (a) a member of the board of the examinee; or
1451 (b) one or more newspapers in this state.

1452 [~~(10)~~] (11) (a) In a proceeding by or against the examinee, or any officer or agent of the
1453 examinee, the examination report as adopted by the commissioner is admissible as evidence of
1454 the facts stated in the report.
1455 (b) In any proceeding commenced under Chapter 27a, Insurer Receivership Act, the
1456 examination report, whether adopted by the commissioner or not, is admissible as evidence of
1457 the facts stated in the examination report.
1458 (12) Work papers are protected records under Title 63G, Chapter 2, Government
1459 Records Access and Management Act.
1460 Section 5. Section **31A-3-303** is amended to read:
1461 **31A-3-303. Payment of tax.**
1462 (1) (a) An insurer, the producers involved in the transaction, and the policyholder are
1463 jointly and severally liable for the payment of the taxes required under Section 31A-3-301.
1464 (b) The policyholder's liability for payment of the premium tax under Section
1465 31A-3-301 ends when the policyholder pays the tax to a producer or an insurer.
1466 (c) The insurer and the producers involved in the transaction are jointly and severally
1467 liable for the payment of the additional tax required under Section 31A-3-302.
1468 (d) Except for the tax under Section 31A-3-302, the policyholder shall pay a tax under
1469 this part and shall be billed specifically for the tax when billed for the premium.
1470 (e) Except for the tax imposed under Section 31A-3-302, absorption of the tax by the
1471 producer or insurer is an unfair method of competition under Sections 31A-23a-402 and
1472 31A-23a-402.5.
1473 (2) (a) The commissioner shall by rule prescribe accounting and reporting forms and
1474 procedures for insurers, producers, and policyholders to use in determining the amount of taxes
1475 owed under this part, and the manner and time of payment.
1476 (b) If a tax is not paid within the time prescribed under the commissioner's rule, a
1477 penalty shall be imposed of 25% of the tax due, plus 1-1/2% per month from the time of
1478 default until full payment of the tax.
1479 (3) Upon making a record of its actions, and upon reasonable cause shown, the
1480 commissioner may waive, reduce, or compromise any of the penalties or interest imposed
1481 under this part.
1482 [~~(4) Subject to Section 31A-3-305, if a policy covers risks that are only partially~~

1483 located in this state, for computation of tax under this part the premium shall be reasonably
1484 allocated among the states on the basis of risk locations. However, the premiums with respect
1485 to surplus lines insurance received in this state by a surplus lines producer or charged on
1486 policies written or negotiated in or from this state are taxable in full under this part, subject to a
1487 credit for any tax actually paid in another state to the extent of a reasonable allocation on the
1488 basis of risk locations.]
1489 (4) When Utah is the home state, premiums for surplus lines insurance are taxable in
1490 full.
1491 (5) Subject to Section 31A-3-305, the premium taxes collected under this part by a
1492 producer or by an insurer are the property of this state.
1493 (6) If the property of a producer is seized under any process in a court in this state, or if
1494 a producer's business is suspended by the action of creditors or put into the hands of an
1495 assignee, receiver, or trustee, the taxes and penalties due this state under this part are preferred
1496 claims and the state is to that extent a preferred creditor.
1497 Section 6. Section **31A-8-104** is amended to read:
1498 **31A-8-104. Determination of ability to provide services.**
1499 (1) The commissioner may not issue a certificate of authority to an applicant for a
1500 certificate of authority under this chapter unless the applicant demonstrates to the
1501 commissioner [has determined] that the applicant has:
1502 (a) [demonstrated] the willingness and potential ability to furnish the proposed health
1503 care services in a manner to assure both availability and accessibility of adequate personnel and
1504 facilities and continuity of service; and
1505 (b) arrangements for an ongoing quality of health care assurance program concerning
1506 health care processes and outcomes[, established in accordance with rules adopted by the
1507 director of the Department of Health based upon prevailing standards for quality assurance for
1508 other forms of health care delivery in this state; and].
1509 [(c) a procedure, established in accordance with rules of the director of the Department
1510 of Health, to develop, compile, evaluate, and report statistics relating to the cost of its
1511 operations, the pattern of utilization of its services, the availability and accessibility of its
1512 services, and such other matters as may be reasonably required by the director of the
1513 Department of Health.]

1514 [~~(2) Upon receipt of an application for a certificate of authority under this chapter, the~~
1515 ~~commissioner shall transmit a copy of the application and accompanying documents to the~~
1516 ~~director of the Department of Health. Upon receipt of the application, the director of the~~
1517 ~~Department of Health shall review the application, investigate the surrounding facts and~~
1518 ~~circumstances, and make a finding concerning whether the applicant satisfies the requirements~~
1519 ~~of Subsection (1). The director of the Department of Health is considered to have found the~~
1520 ~~applicant to comply with Subsection (1) unless he delivers to the commissioner a finding of~~
1521 ~~noncompliance within 90 days after receiving the application from the commissioner.~~]
1522 [~~(3) In determining whether the requirements of Subsection (1) are satisfied, the~~
1523 ~~commissioner shall rely on the findings of the director of the Department of Health delivered to~~
1524 ~~the commissioner in accordance with Subsection (2).~~]
1525 [~~(4) A finding of noncompliance with Subsection (1) shall specify in what respects the~~
1526 ~~applicant is deficient in meeting the requirements of Subsection (1).~~]
1527 (2) (a) In accordance with Sections 31A-2-203 and 31A-2-204, the commissioner may
1528 order an independent audit or examination by one or more technical experts to determine an
1529 applicant's ability to provide the proposed health care services as described in Subsection (1).
1530 (b) In accordance with Section 31A-2-205, an applicant shall reimburse the
1531 commissioner for the reasonable cost of an independent audit or examination.
1532 [~~(5) An organization's certificate of authority issued under this chapter is conclusive~~
1533 ~~evidence of compliance with Subsection (1), as to the services authorized to be performed~~
1534 ~~under the certificate of authority, except in a proceeding by the state against the organization.~~]
1535 (3) Licensing under this chapter does not exempt an organization from any licensing
1536 requirement applicable under Title 26, Chapter 21, Health Care Facility Licensing and
1537 Inspection Act.
1538 Section 7. Section **31A-8a-102** is amended to read:
1539 **31A-8a-102. Definitions.**
1540 [~~For purposes of~~] As used in this chapter:
1541 (1) "Fee" means any periodic charge for use of a discount program.
1542 (2) "Health care provider" means a health care provider as defined in Section
1543 78B-3-403, with the exception of "licensed athletic trainer," who:
1544 (a) is practicing within the scope of the provider's license; and

1545 (b) has agreed either directly or indirectly, by contract or any other arrangement with a
1546 health discount program operator, to provide a discount to enrollees of a health discount
1547 program.
1548 (3) (a) "Health discount program" means a business arrangement or contract in which a
1549 person pays fees, dues, charges, or other consideration in exchange for a program that provides
1550 access to health care providers who agree to provide a discount for health care services.
1551 (b) "Health discount program" does not include a program that does not charge a
1552 membership fee or require other consideration from the member to use the program's discounts
1553 for health services.
1554 (4) "Health discount program marketer" means a person, including a private label
1555 entity, that markets, promotes, sells, or distributes a health discount program but does not
1556 operate a health discount program.
1557 (5) "Health discount program operator" means a person that provides a health discount
1558 program by entering into a contract or agreement, directly or indirectly, with a person or
1559 persons in this state who agree to provide discounts for health care services to enrollees of the
1560 health discount program and determines the charge to members.
1561 (6) "Marketing" means making or causing to be made any communication that contains
1562 information that relates to a product or contract regulated under this chapter.
1563 [(6)] (7) "Value-added benefit" means a discount offering with no additional charge
1564 made by a health insurer or health maintenance organization that is licensed under this title, in
1565 connection with existing contracts with the health insurer or health maintenance organization.
1566 Section 8. Section **31A-15-103** is amended to read:
1567 **31A-15-103. Surplus lines insurance -- Unauthorized insurers.**
1568 (1) Notwithstanding Section 31A-15-102, [a foreign] Ĥ→ **[an insurer that has not obtained a**
1569 **certificate of authority to do business in this state under Section 31A-14-202 may negotiate for**
1570 **and] when this state is the home state as defined in Section 31A-3-305, a nonadmitted insurer**
1570a **may** ←Ĥ make an insurance contract Ĥ→ **[with] for coverage of** ←Ĥ a person in this state and on
1570b a risk located in this state,
1571 subject to the limitations and requirements of this section.
1572 (2) (a) For a contract made under this section, the insurer may, in this state:
1573 (i) inspect the risks to be insured;
1574 (ii) collect premiums;
1575 (iii) adjust losses; and

1576 (iv) do another act reasonably incidental to the contract.
1577 (b) An act described in Subsection (2)(a) may be done through:
1578 (i) an employee; or
1579 (ii) an independent contractor.
1580 (3) (a) Subsections (1) and (2) do not permit a person to solicit business in this state on
1581 behalf of an insurer that has no certificate of authority.
1582 (b) Insurance placed with a nonadmitted insurer shall be placed [~~with~~] by a surplus
1583 lines producer licensed under Chapter 23a, Insurance Marketing - Licensing Producers,
1584 Consultants, and Reinsurance Intermediaries.
1585 (c) The commissioner may by rule prescribe how a surplus lines producer may:
1586 (i) pay or permit the payment, commission, or other remuneration on insurance placed
1587 by the surplus lines producer under authority of the surplus lines producer's license to one
1588 holding a license to act as an insurance producer; and
1589 (ii) advertise the availability of the surplus lines producer's services in procuring, on
1590 behalf of a person seeking insurance, a contract with a nonadmitted insurer.
1591 (4) For a contract made under this section, a nonadmitted insurer is subject to Sections
1592 31A-23a-402, 31A-23a-402.5, and 31A-23a-403 and the rules adopted under those sections.
1593 (5) A nonadmitted insurer may not issue workers' compensation insurance coverage to
1594 an employer located in this state, except for stop loss coverage issued to an employer securing
1595 workers' compensation under Subsection 34A-2-201(2).
1596 (6) (a) The commissioner may by rule prohibit making a contract under Subsection (1)
1597 for a specified class of insurance if authorized insurers provide an established market for the
1598 class in this state that is adequate and reasonably competitive.
1599 (b) The commissioner may by rule place a restriction or a limitation on and create
1600 special procedures for making a contract under Subsection (1) for a specified class of insurance
1601 if:
1602 (i) there have been abuses of placements in the class; or
1603 (ii) the policyholders in the class, because of limited financial resources, business
1604 experience, or knowledge, cannot protect their own interests adequately.
1605 (c) The commissioner may prohibit an individual insurer from making a contract under
1606 Subsection (1) and all insurance producers from dealing with the insurer if:

1607 (i) the insurer willfully violates:
1608 (A) this section;
1609 (B) Section 31A-4-102, 31A-23a-402, 31A-23a-402.5, or 31A-26-303; or
1610 (C) a rule adopted under a section listed in Subsection (6)(c)(i)(A) or (B);
1611 (ii) the insurer fails to pay the fees and taxes specified under Section 31A-3-301; or
1612 (iii) the commissioner has reason to believe that the insurer is:
1613 (A) in an unsound condition;
1614 (B) operated in a fraudulent, dishonest, or incompetent manner; or
1615 (C) in violation of the law of its domicile.
1616 (d) (i) The commissioner may issue one or more lists of Ĥ→ **[~~unauthorized~~]**
1616a **nonadmitted** ←Ĥ foreign insurers
1617 whose:
1618 (A) solidity the commissioner doubts; or
1619 (B) practices the commissioner considers objectionable.
1620 (ii) The commissioner shall issue one or more lists of Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ
1620a foreign insurers the
1621 commissioner considers to be reliable and solid.
1622 (iii) In addition to the lists described in Subsections (6)(d)(i) and (ii), the commissioner
1623 may issue other relevant evaluations of Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ insurers.
1624 (iv) An action may not lie against the commissioner or an employee of the department
1625 for a written or oral communication made in, or in connection with the issuance of, a list or
1626 evaluation described in this Subsection (6)(d).
1627 (e) [~~A foreign~~] Ĥ→ **[~~An unauthorized~~] A nonadmitted** ←Ĥ insurer shall be listed on the
1627a commissioner's "reliable"
1628 list only if the Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ insurer:
1629 (i) delivers a request to the commissioner to be on the list;
1630 (ii) establishes satisfactory evidence of good reputation and financial integrity;
1631 (iii) (A) delivers to the commissioner a copy of the Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ
1631a insurer's current
1632 annual statement certified by the insurer[~~; and~~] and, each subsequent year, delivers to the
1633 commissioner a copy of the Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ insurer's annual statement
1633a within 60 days after the
1634 day on which the Ĥ→ **[~~unauthorized~~] nonadmitted** ←Ĥ insurer files the annual statement with the
1634a insurance regulatory
1635 authority where the Ĥ→ **nonadmitted** ←Ĥ insurer is domiciled; or
1636 [~~(B) continues each subsequent year to file its annual statements with the~~
1637 ~~commissioner within 60 days of the day on which it is filed with the insurance regulatory~~

1638 authority where the insurer is domiciled;]
1639 (B) files the Ĥ→ [**unauthorized**] **nonadmitted** ←Ĥ insurer's annual statements with the
1639a National Association of
1640 Insurance Commissioners and the Ĥ→ [**unauthorized**] **nonadmitted** ←Ĥ insurer's annual
1640a statements are available
1641 electronically from the National Association of Insurance Commissioners;
1642 (iv) (A) [(I)] is in substantial compliance with the solvency standards in Chapter 17,
1643 Part 6, Risk-Based Capital, or maintains capital and surplus of at least $15,000,000, whichever
1644 is greater; [and] or
1645 [(II) maintains in the United States an irrevocable trust fund in either a national bank or
1646 a member of the Federal Reserve System, or maintains a deposit meeting the statutory deposit
1647 requirements for insurers in the state where it is made, which trust fund or deposit:]
1648 [(Aa) shall be in an amount not less than $2,500,000 for the protection of all of the
1649 insurer's policyholders in the United States;]
1650 [(Bb) may consist of cash, securities, or investments of substantially the same character
1651 and quality as those which are "qualified assets" under Section 31A-17-201; and]
1652 [(Cc) may include as part of the trust arrangement a letter of credit that qualifies as
1653 acceptable security under Section 31A-17-404.1; or]
1654 (B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group
1655 of alien individual insurers, maintains a trust fund that:
1656 (I) shall be in an amount not less than $50,000,000 as security to its full amount for all
1657 policyholders and creditors in the United States of each member of the group;
1658 (II) may consist of cash, securities, or investments of substantially the same character
1659 and quality as those which are "qualified assets" under Section 31A-17-201; and
1660 (III) may include as part of this trust arrangement a letter of credit that qualifies as
1661 acceptable security under Section 31A-17-404.1; and
1662 (v) for an alien insurer not domiciled in the United States or a territory of the United
1663 States, is listed on the Quarterly Listing of Alien Insurers maintained by the National
1664 Association of Insurance Commissioners International Insurers Department.
1665 (7) (a) Subject to Subsection (7)(b), a surplus lines producer may not, either knowingly
1666 or without reasonable investigation of the financial condition and general reputation of the
1667 insurer, place insurance under this section with:
1668 (i) a financially unsound insurer;

1669 (ii) an insurer engaging in unfair practices; or
1670 (iii) an otherwise substandard insurer.
1671 (b) A surplus line producer may place insurance under this section with an insurer
1672 described in Subsection (7)(a) if the surplus line producer:
1673 (i) gives the applicant notice in writing of the known deficiencies of the insurer or the
1674 limitations on the surplus line producer's investigation; and
1675 (ii) explains the need to place the business with that insurer.
1676 (c) A copy of the notice described in Subsection (7)(b) shall be kept in the office of the
1677 surplus line producer for at least five years.
1678 (d) To be financially sound, an insurer shall satisfy standards that are comparable to
1679 those applied under the laws of this state to an authorized insurer.
1680 (e) An insurer on the "doubtful or objectionable" list under Subsection (6)(d) or an
1681 insurer not on the commissioner's "reliable" list under Subsection (6)(e) is presumed
1682 substandard.
1683 (8) (a) A policy issued under this section shall:
1684 (i) include a description of the subject of the insurance; and
1685 (ii) indicate:
1686 (A) the coverage, conditions, and term of the insurance;
1687 (B) the premium charged the policyholder;
1688 (C) the premium taxes to be collected from the policyholder; and
1689 (D) the name and address of the policyholder and insurer.
1690 (b) If the direct risk is assumed by more than one insurer, the policy shall state:
1691 (i) the names and addresses of all insurers; and
1692 (ii) the portion of the entire direct risk each assumes.
1693 (c) A policy issued under this section shall have attached or affixed to the policy the
1694 following statement: "The insurer issuing this policy does not hold a certificate of authority to
1695 do business in this state and thus is not fully subject to regulation by the Utah insurance
1696 commissioner. This policy receives no protection from any of the guaranty associations created
1697 under Title 31A, Chapter 28, Guaranty Associations."
1698 (9) Upon placing a new or renewal coverage under this section, a surplus lines
1699 producer shall promptly deliver to the policyholder or the policyholder's agent evidence of the

1700 insurance consisting either of:
1701 (a) the policy as issued by the insurer; or
1702 (b) if the policy is not available upon placing the coverage, a certificate, cover note, or
1703 other confirmation of insurance complying with Subsection (8).
1704 (10) If the commissioner finds it necessary to protect the interests of insureds and the
1705 public in this state, the commissioner may by rule subject a policy issued under this section to
1706 as much of the regulation provided by this title as is required for a comparable policy written
1707 by an authorized foreign insurer.
1708 (11) (a) A surplus lines transaction in this state shall be examined to determine whether
1709 it complies with:
1710 (i) the surplus lines tax levied under Chapter 3, Department Funding, Fees, and Taxes;
1711 (ii) the solicitation limitations of Subsection (3);
1712 (iii) the requirement of Subsection (3) that placement be through a surplus lines
1713 producer;
1714 (iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and
1715 (v) the policy form requirements of Subsections (8) and (10).
1716 (b) The examination described in Subsection (11)(a) shall take place as soon as
1717 practicable after the transaction. The surplus lines producer shall submit to the examiner
1718 information necessary to conduct the examination within a period specified by rule.
1719 (c) (i) The examination described in Subsection (11)(a) may be conducted by the
1720 commissioner or by an advisory organization created under Section 31A-15-111 and authorized
1721 by the commissioner to conduct these examinations. The commissioner is not required to
1722 authorize an additional advisory organization to conduct an examination under this Subsection
1723 (11)(c).
1724 (ii) The commissioner's authorization of one or more advisory organizations to act as
1725 examiners under this Subsection (11)(c) shall be:
1726 (A) by rule; and
1727 (B) evidenced by a contract, on a form provided by the commissioner, between the
1728 authorized advisory organization and the department.
1729 (d) (i) (A) A person conducting the examination described in Subsection (11)(a) shall
1730 collect a stamping fee of an amount not to exceed 1% of the policy premium payable in

1731 connection with the transaction.
1732 (B) A stamping fee collected by the commissioner shall be deposited in the General
1733 Fund.
1734 (C) The commissioner shall establish a stamping fee by rule.
1735 (ii) A stamping fee collected by an advisory organization is the property of the advisory
1736 organization to be used in paying the expenses of the advisory organization.
1737 (iii) Liability for paying a stamping fee is as required under Subsection 31A-3-303(1)
1738 for taxes imposed under Section 31A-3-301.
1739 (iv) The commissioner shall adopt a rule dealing with the payment of stamping fees. If
1740 a stamping fee is not paid when due, the commissioner or advisory organization may impose a
1741 penalty of 25% of the stamping fee due, plus 1-1/2% per month from the time of default until
1742 full payment of the stamping fee.
1743 [~~(v) A stamping fee relative to a policy covering a risk located partially in this state~~
1744 ~~shall be allocated in the same manner as under Subsection 31A-3-303(4).~~]
1745 (e) The commissioner, representatives of the department, advisory organizations,
1746 representatives and members of advisory organizations, authorized insurers, and surplus lines
1747 insurers are not liable for damages on account of statements, comments, or recommendations
1748 made in good faith in connection with their duties under this Subsection (11)(e) or under
1749 Section 31A-15-111.
1750 (f) An examination conducted under this Subsection (11) and a document or materials
1751 related to the examination are confidential.
1752 (12) (a) For a surplus lines insurance transaction in the state entered into on or after
1753 May 13, 2014, if an audit is required by the surplus lines insurance policy, a surplus lines
1754 insurer:
1755 (i) shall exercise due diligence to initiate an audit of an insured, to determine whether
1756 additional premium is owed by the insured, by no later than six months after the expiration of
1757 the term for which premium is paid; and
1758 (ii) may not audit an insured more than three years after the surplus lines insurance
1759 policy expires.
1760 (b) A surplus lines insurer that does not comply with this Subsection (12) may not
1761 charge or collect additional premium in excess of the premium agreed to under the surplus

1762 lines insurance policy.
1763 Section 9. Section **31A-16-103** is amended to read:
1764 **31A-16-103. Acquisition of control of, divestiture of control of, or merger with**
1765 **domestic insurer.**
1766 (1) (a) A person may not take the actions described in Subsection (1)(b) or (c) unless,
1767 at the time any offer, request, or invitation is made or any such agreement is entered into, or
1768 prior to the acquisition of securities if no offer or agreement is involved:
1769 (i) the person files with the commissioner a statement containing the information
1770 required by this section;
1771 (ii) the person provides a copy of the statement described in Subsection (1)(a)(i) to the
1772 insurer; and
1773 (iii) the commissioner approves the offer, request, invitation, agreement, or acquisition.
1774 (b) Unless the person complies with Subsection (1)(a), a person other than the issuer
1775 may not make a tender offer for, a request or invitation for tenders of, or enter into any
1776 agreement to exchange securities, or seek to acquire or acquire in the open market or otherwise,
1777 any voting security of a domestic insurer if after the acquisition, the person would directly,
1778 indirectly, by conversion, or by exercise of any right to acquire be in control of the insurer.
1779 (c) Unless the person complies with Subsection (1)(a), a person may not enter into an
1780 agreement to merge with or otherwise to acquire control of:
1781 (i) a domestic insurer; or
1782 (ii) any person controlling a domestic insurer.
1783 (d) For purposes of this section, a controlling person of a domestic insurer seeking to
1784 divest its controlling interest in the domestic insurer, in any manner, shall file with the
1785 commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least
1786 30 days before the cessation of control. The commissioner shall determine those instances in
1787 which the one or more persons seeking to divest or to acquire a controlling interest in an
1788 insurer, will be required to file for and obtain approval of the transaction. The information
1789 shall remain confidential until the conclusion of the transaction unless the commissioner, in the
1790 commissioner's discretion, determines that confidential treatment will interfere with
1791 enforcement of this section. If the statement referred to in Subsection (1)(a) is otherwise filed,
1792 this Subsection (1)(d) does not apply.

1793 (e) With respect to a transaction subject to this section, the acquiring person shall also
1794 file a pre-acquisition notification with the commissioner, which shall contain the information
1795 set forth in Section 31A-16-104.5. A failure to file the notification may be subject to penalties
1796 specified in Section 31A-16-104.5.
1797 (f) (i) For purposes of this section, a domestic insurer includes any person controlling a
1798 domestic insurer unless the person as determined by the commissioner is either directly or
1799 through its affiliates primarily engaged in business other than the business of insurance.
1800 (ii) The controlling person described in Subsection (1)(f)(i) shall file with the
1801 commissioner a preacquisition notification containing the information required in Subsection
1802 (2) 30 calendar days before the proposed effective date of the acquisition.
1803 (iii) For the purposes of this section, "person" does not include any securities broker
1804 that in the usual and customary brokers function holds less than 20% of:
1805 (A) the voting securities of an insurance company; or
1806 (B) any person that controls an insurance company.
1807 (iv) This section applies to all domestic insurers and other entities licensed under:
1808 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
1809 (B) Chapter 7, Nonprofit Health Service Insurance Corporations;
1810 (C) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
1811 (D) Chapter 9, Insurance Fraternals; and
1812 (E) Chapter 11, Motor Clubs.
1813 (g) (i) An agreement for acquisition of control or merger as contemplated by this
1814 Subsection (1) is not valid or enforceable unless the agreement:
1815 (A) is in writing; and
1816 (B) includes a provision that the agreement is subject to the approval of the
1817 commissioner upon the filing of any applicable statement required under this chapter.
1818 (ii) A written agreement for acquisition or control that includes the provision described
1819 in Subsection (1)(g)(i) satisfies the requirements of this Subsection (1).
1820 (2) The statement to be filed with the commissioner under Subsection (1) shall be
1821 made under oath or affirmation and shall contain the following information:
1822 (a) the name and address of the "acquiring party," which means each person by whom
1823 or on whose behalf the merger or other acquisition of control referred to in Subsection (1) is to

1824 be effected; and
1825 (i) if the person is an individual:
1826 (A) the person's principal occupation;
1827 (B) a listing of all offices and positions held by the person during the past five years;
1828 and
1829 (C) any conviction of crimes other than minor traffic violations during the past 10
1830 years; and
1831 (ii) if the person is not an individual:
1832 (A) a report of the nature of its business operations during:
1833 (I) the past five years; or
1834 (II) for any lesser period as the person and any of its predecessors has been in
1835 existence;
1836 (B) an informative description of the business intended to be done by the person and
1837 the person's subsidiaries;
1838 (C) a list of all individuals who are or who have been selected to become directors or
1839 executive officers of the person, or individuals who perform, or who will perform functions
1840 appropriate to such positions; and
1841 (D) for each individual described in Subsection (2)(a)(ii)(C), the information required
1842 by Subsection (2)(a)(i) for each individual;
1843 (b) (i) the source, nature, and amount of the consideration used or to be used in
1844 effecting the merger or acquisition of control;
1845 (ii) a description of any transaction in which funds were or are to be obtained for the
1846 purpose of effecting the merger or acquisition of control, including any pledge of:
1847 (A) the insurer's stock; or
1848 (B) the stock of any of the insurer's subsidiaries or controlling affiliates; and
1849 (iii) the identity of persons furnishing the consideration;
1850 (c) (i) fully audited financial information, or other financial information considered
1851 acceptable by the commissioner, of the earnings and financial condition of each acquiring party
1852 for:
1853 (A) the preceding five fiscal years of each acquiring party; or
1854 (B) any lesser period the acquiring party and any of its predecessors shall have been in

1855 existence; and
1856 (ii) unaudited information:
1857 (A) similar to the information described in Subsection (2)(c)(i); and
1858 (B) prepared within the 90 days prior to the filing of the statement;
1859 (d) any plans or proposals which each acquiring party may have to:
1860 (i) liquidate the insurer;
1861 (ii) sell its assets;
1862 (iii) merge or consolidate the insurer with any person; or
1863 (iv) make any other material change in the insurer's:
1864 (A) business;
1865 (B) corporate structure; or
1866 (C) management;
1867 (e) (i) the number of shares of any security referred to in Subsection (1) that each
1868 acquiring party proposes to acquire;
1869 (ii) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1870 Subsection (1); and
1871 (iii) a statement as to the method by which the fairness of the proposal was arrived at;
1872 (f) the amount of each class of any security referred to in Subsection (1) that:
1873 (i) is beneficially owned; or
1874 (ii) concerning which there is a right to acquire beneficial ownership by each acquiring
1875 party;
1876 (g) a full description of any contract, arrangement, or understanding with respect to any
1877 security referred to in Subsection (1) in which any acquiring party is involved, including:
1878 (i) the transfer of any of the securities;
1879 (ii) joint ventures;
1880 (iii) loan or option arrangements;
1881 (iv) puts or calls;
1882 (v) guarantees of loans;
1883 (vi) guarantees against loss or guarantees of profits;
1884 (vii) division of losses or profits; or
1885 (viii) the giving or withholding of proxies;

1886 (h) a description of the purchase by any acquiring party of any security referred to in
1887 Subsection (1) during the 12 calendar months preceding the filing of the statement including:
1888 (i) the dates of purchase;
1889 (ii) the names of the purchasers; and
1890 (iii) the consideration paid or agreed to be paid for the purchase;
1891 (i) a description of:
1892 (i) any recommendations to purchase by any acquiring party any security referred to in
1893 Subsection (1) made during the 12 calendar months preceding the filing of the statement; or
1894 (ii) any recommendations made by anyone based upon interviews or at the suggestion
1895 of the acquiring party;
1896 (j) (i) copies of all tender offers for, requests for, or invitations for tenders of, exchange
1897 offers for, and agreements to acquire or exchange any securities referred to in Subsection (1);
1898 and
1899 (ii) if distributed, copies of additional soliciting material relating to the transactions
1900 described in Subsection (2)(j)(i);
1901 (k) (i) the term of any agreement, contract, or understanding made with, or proposed to
1902 be made with, any broker-dealer as to solicitation of securities referred to in Subsection (1) for
1903 tender; and
1904 (ii) the amount of any fees, commissions, or other compensation to be paid to
1905 broker-dealers with regard to any agreement, contract, or understanding described in
1906 Subsection (2)(k)(i);
1907 (l) an agreement by the person required to file the statement referred to in Subsection
1908 (1) that it will provide the annual report, specified in Section 31A-16-105, for so long as
1909 control exists;
1910 (m) an acknowledgment by the person required to file the statement referred to in
1911 Subsection (1) that the person and all subsidiaries within its control in the insurance holding
1912 company system will provide information to the commissioner upon request as necessary to
1913 evaluate enterprise risk to the insurer; and
1914 (n) any additional information the commissioner requires by rule, which the
1915 commissioner determines to be:
1916 (i) necessary or appropriate for the protection of policyholders of the insurer; or

1917 (ii) in the public interest.
1918 (3) The department may request:
1919 (a) (i) criminal background information maintained pursuant to Title 53, Chapter 10,
1920 Part 2, Bureau of Criminal Identification, from the Bureau of Criminal Identification; and
1921 (ii) complete Federal Bureau of Investigation criminal background checks through the
1922 national criminal history system.
1923 (b) Information obtained by the department from the review of criminal history records
1924 received under Subsection (3)(a) shall be used by the department for the purpose of:
1925 (i) verifying the information in Subsection (2)(a)(i);
1926 (ii) determining the integrity of persons who would control the operation of an insurer;
1927 and
1928 (iii) preventing persons who violate 18 U.S.C. Sec. 1033 from engaging in the business
1929 of insurance in the state.
1930 (c) If the department requests the criminal background information, the department
1931 shall:
1932 (i) pay to the Department of Public Safety the costs incurred by the Department of
1933 Public Safety in providing the department criminal background information under Subsection
1934 (3)(a)(i);
1935 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau
1936 of Investigation in providing the department criminal background information under
1937 Subsection (3)(a)(ii); and
1938 (iii) charge the person required to file the statement referred to in Subsection (1) a fee
1939 equal to the aggregate of Subsections (3)(c)(i) and (ii).
1940 (4) (a) If the source of the consideration under Subsection (2)(b)(i) is a loan made in
1941 the lender's ordinary course of business, the identity of the lender shall remain confidential, if
1942 the person filing the statement so requests.
1943 (b) (i) Under Subsection (2)(e), the commissioner may require a statement of the
1944 adjusted book value assigned by the acquiring party to each security in arriving at the terms of
1945 the offer.
1946 (ii) For purposes of this Subsection (4)(b), "adjusted book value" means each security's
1947 proportional interest in the capital and surplus of the insurer with adjustments that reflect:

1948 (A) market conditions;
1949 (B) business in force; and
1950 (C) other intangible assets or liabilities of the insurer.
1951 (c) The description required by Subsection (2)(g) shall identify the persons with whom
1952 the contracts, arrangements, or understandings have been entered into.
1953 (5) (a) If the person required to file the statement referred to in Subsection (1) is a
1954 partnership, limited partnership, syndicate, or other group, the commissioner may require that
1955 all the information called for by Subsection (2), (3), or (4) shall be given with respect to each:
1956 (i) partner of the partnership or limited partnership;
1957 (ii) member of the syndicate or group; and
1958 (iii) person who controls the partner or member.
1959 (b) If any partner, member, or person referred to in Subsection (5)(a) is a corporation,
1960 or if the person required to file the statement referred to in Subsection (1) is a corporation, the
1961 commissioner may require that the information called for by Subsection (2) shall be given with
1962 respect to:
1963 (i) the corporation;
1964 (ii) each officer and director of the corporation; and
1965 (iii) each person who is directly or indirectly the beneficial owner of more than 10% of
1966 the outstanding voting securities of the corporation.
1967 (6) If any material change occurs in the facts set forth in the statement filed with the
1968 commissioner and sent to the insurer pursuant to Subsection (2), an amendment setting forth
1969 the change, together with copies of all documents and other material relevant to the change,
1970 shall be filed with the commissioner and sent to the insurer within two business days after the
1971 filing person learns of such change.
1972 (7) If any offer, request, invitation, agreement, or acquisition referred to in Subsection
1973 (1) is proposed to be made by means of a registration statement under the Securities Act of
1974 1933, or under circumstances requiring the disclosure of similar information under the
1975 Securities Exchange Act of 1934, or under a state law requiring similar registration or
1976 disclosure, a person required to file the statement referred to in Subsection (1) may use copies
1977 of any registration or disclosure documents in furnishing the information called for by the
1978 statement.

1979 (8) (a) The commissioner shall approve any merger or other acquisition of control
1980 referred to in Subsection (1), unless[~~, after a public hearing on the merger or acquisition,~~] the
1981 commissioner finds that:
1982 (i) after the change of control, the domestic insurer referred to in Subsection (1) would
1983 not be able to satisfy the requirements for the issuance of a license to write the line or lines of
1984 insurance for which it is presently licensed;
1985 (ii) the effect of the merger or other acquisition of control would:
1986 (A) substantially lessen competition in insurance in this state; or
1987 (B) tend to create a monopoly in insurance;
1988 (iii) the financial condition of any acquiring party might:
1989 (A) jeopardize the financial stability of the insurer; or
1990 (B) prejudice the interest of:
1991 (I) its policyholders; or
1992 (II) any remaining securityholders who are unaffiliated with the acquiring party;
1993 (iv) the terms of the offer, request, invitation, agreement, or acquisition referred to in
1994 Subsection (1) are unfair and unreasonable to the securityholders of the insurer;
1995 (v) the plans or proposals which the acquiring party has to liquidate the insurer, sell its
1996 assets, or consolidate or merge it with any person, or to make any other material change in its
1997 business or corporate structure or management, are:
1998 (A) unfair and unreasonable to policyholders of the insurer; and
1999 (B) not in the public interest; or
2000 (vi) the competence, experience, and integrity of those persons who would control the
2001 operation of the insurer are such that it would not be in the interest of the policyholders of the
2002 insurer and the public to permit the merger or other acquisition of control.
2003 (b) For purposes of Subsection (8)(a)(iv), the offering price for each security may not
2004 be considered unfair if the adjusted book values under Subsection (2)(e):
2005 (i) are disclosed to the securityholders; and
2006 (ii) determined by the commissioner to be reasonable.
2007 (9) For a merger or other acquisition of control described in Subsection (1), the
2008 commissioner:
2009 (a) may hold a public hearing on the merger or other acquisition at the commissioner's

2010 discretion; and
2011 (b) shall hold a public hearing on the merger or other acquisition upon request by the
2012 acquiring party, the insurer, or any other interested party.
2013 [(9)] (10) (a) The commissioner shall hold a public hearing [referred to in Subsection
2014 (8) shall be held within 30] under Subsection (9) no later than 45 days after the day on which
2015 the statement required by Subsection (1) is filed.
2016 (b) (i) [At] The commissioner shall give at least 20 days notice of the hearing [shall be
2017 given by the commissioner] to the person filing the statement.
2018 (ii) Affected parties may waive the notice required by this Subsection (9)(b).
2019 (iii) Not less than seven days notice of the public hearing shall be given by the person
2020 filing the statement to:
2021 (A) the insurer; and
2022 (B) any person designated by the commissioner.
2023 (c) The commissioner shall make a determination within 30 days after the conclusion
2024 of the hearing.
2025 (d) At the hearing, the person filing the statement, the insurer, any person to whom
2026 notice of hearing was sent, and any other person whose interest may be affected by the hearing
2027 may:
2028 (i) present evidence;
2029 (ii) examine and cross-examine witnesses; and
2030 (iii) offer oral and written arguments.
2031 (e) (i) A person or insurer described in Subsection [(9)] (10)(d) may conduct discovery
2032 proceedings in the same manner as is presently allowed in the district courts of this state.
2033 (ii) All discovery proceedings shall be concluded not later than three days before the
2034 commencement of the public hearing.
2035 [(10)] (11) If the proposed acquisition of control will require the approval of more than
2036 one commissioner, the public hearing [referred to] described in Subsection (9)[(a)] may be held
2037 on a consolidated basis upon request of the person filing the statement referred to in Subsection
2038 (1). The person shall file the statement referred to in Subsection (1) with the National
2039 Association of Insurance Commissioners within five days of making the request for a public
2040 hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the

2041 applicant of the opt-out within 10 days of the receipt of the statement referred to in Subsection
2042 (1). A hearing conducted on a consolidated basis shall be public and shall be held within the
2043 United States before the commissioners of the states in which the insurers are domiciled. The
2044 commissioners shall hear and receive evidence. A commissioner may attend a hearing under
2045 this Subsection [~~(10)~~] (11) in person or by telecommunication.
2046 [~~(11)~~] (12) In connection with a change of control of a domestic insurer, any
2047 determination by the commissioner that the person acquiring control of the insurer shall be
2048 required to maintain or restore the capital of the insurer to the level required by the laws and
2049 regulations of this state shall be made not later than 60 days after the date of notification of the
2050 change in control submitted pursuant to Subsection (1).
2051 [~~(12)~~] (13) (a) The commissioner may retain technical experts to assist in reviewing all,
2052 or a portion of, information filed in connection with a proposed merger or other acquisition of
2053 control referred to in Subsection (1).
2054 (b) In determining whether any of the conditions in Subsection (8) exist, the
2055 commissioner may consider the findings of technical experts employed to review applicable
2056 filings.
2057 (c) (i) A technical expert employed under Subsection [~~(12)~~] (13)(a) shall present to the
2058 commissioner a statement of all expenses incurred by the technical expert in conjunction with
2059 the technical expert's review of a proposed merger or other acquisition of control.
2060 (ii) At the commissioner's direction the acquiring person shall compensate the technical
2061 expert at customary rates for time and expenses:
2062 (A) necessarily incurred; and
2063 (B) approved by the commissioner.
2064 (iii) The acquiring person shall:
2065 (A) certify the consolidated account of all charges and expenses incurred for the review
2066 by technical experts;
2067 (B) retain a copy of the consolidated account described in Subsection [~~(12)~~]
2068 (13)(c)(iii)(A); and
2069 (C) file with the department as a public record a copy of the consolidated account
2070 described in Subsection [~~(12)~~] (13)(c)(iii)(A).
2071 [~~(13)~~] (14) (a) (i) If a domestic insurer proposes to merge into another insurer, any

2072 securityholder electing to exercise a right of dissent may file with the insurer a written request
2073 for payment of the adjusted book value given in the statement required by Subsection (1) and
2074 approved under Subsection (8), in return for the surrender of the security holder's securities.
2075 (ii) The request described in Subsection [(13)] (14)(a)(i) shall be filed not later than 10
2076 days after the day of the securityholders' meeting where the corporate action is approved.
2077 (b) The dissenting securityholder is entitled to and the insurer is required to pay to the
2078 dissenting securityholder the specified value within 60 days of receipt of the dissenting security
2079 holder's security.
2080 (c) Persons electing under this Subsection [(13)] (14) to receive cash for their securities
2081 waive the dissenting shareholder and appraisal rights otherwise applicable under Title 16,
2082 Chapter 10a, Part 13, Dissenters' Rights.
2083 (d) (i) This Subsection [(13)] (14) provides an elective procedure for dissenting
2084 securityholders to resolve their objections to the plan of merger.
2085 (ii) This section does not restrict the rights of dissenting securityholders under Title 16,
2086 Chapter 10a, Utah Revised Business Corporation Act, unless this election is made under this
2087 Subsection [(13)] (14).
2088 [(14)] (15) (a) All statements, amendments, or other material filed under Subsection
2089 (1), and all notices of public hearings held under Subsection (8), shall be mailed by the insurer
2090 to its securityholders within five business days after the insurer has received the statements,
2091 amendments, other material, or notices.
2092 (b) (i) Mailing expenses shall be paid by the person making the filing.
2093 (ii) As security for the payment of mailing expenses, that person shall file with the
2094 commissioner an acceptable bond or other deposit in an amount determined by the
2095 commissioner.
2096 [(15)] (16) This section does not apply to any offer, request, invitation, agreement, or
2097 acquisition that the commissioner by order exempts from the requirements of this section as:
2098 (a) not having been made or entered into for the purpose of, and not having the effect
2099 of, changing or influencing the control of a domestic insurer; or
2100 (b) otherwise not comprehended within the purposes of this section.
2101 [(16)] (17) The following are violations of this section:
2102 (a) the failure to file any statement, amendment, or other material required to be filed

2103 pursuant to Subsections (1), (2), and (5); or
2104 (b) the effectuation, or any attempt to effectuate, an acquisition of control of,
2105 divestiture of, or merger with a domestic insurer unless the commissioner has given the
2106 commissioner's approval to the acquisition or merger.
2107 [~~(17)~~] <u>(18)</u> (a) The courts of this state are vested with jurisdiction over:
2108 (i) a person who:
2109 (A) files a statement with the commissioner under this section; and
2110 (B) is not resident, domiciled, or authorized to do business in this state; and
2111 (ii) overall actions involving persons described in Subsection [~~(17)~~] <u>(18)</u>(a)(i) arising
2112 out of a violation of this section.
2113 (b) A person described in Subsection [~~(17)~~] <u>(18)</u>(a) is considered to have performed
2114 acts equivalent to and constituting an appointment of the commissioner by that person, to be
2115 that person's lawful agent upon whom may be served all lawful process in any action, suit, or
2116 proceeding arising out of a violation of this section.
2117 (c) A copy of a lawful process described in Subsection [~~(17)~~] <u>(18)</u>(b) shall be:
2118 (i) served on the commissioner; and
2119 (ii) transmitted by registered or certified mail by the commissioner to the person at that
2120 person's last-known address.
2121 Section 10. Section **31A-22-612** is amended to read:
2122 **31A-22-612. Conversion privileges for insured former spouse.**
2123 (1) An accident and health insurance policy, which in addition to covering the insured
2124 also provides coverage to the spouse of the insured, may not contain a provision for
2125 termination of coverage of a spouse covered under the policy, except by entry of a valid decree
2126 of divorce<u>, legal separation,</u> or annulment between the parties.
2127 (2) Every policy which contains this type of provision shall provide that upon the entry
2128 of the divorce decree the spouse is entitled to have issued an individual policy of accident and
2129 health insurance without evidence of insurability, upon application to the company and
2130 payment of the appropriate premium. The policy shall provide the coverage being issued
2131 which is most nearly similar to the terminated coverage. Probationary or waiting periods in the
2132 policy are considered satisfied to the extent the coverage was in force under the prior policy.
2133 (3) When the insurer receives actual notice that the coverage of a spouse is to be

2134 terminated because of a divorce, legal separation, or annulment, the insurer shall promptly
2135 provide the spouse written notification of the right to obtain individual coverage as provided in
2136 Subsection (2), the premium amounts required, and the manner, place, and time in which
2137 premiums may be paid. The premium is determined in accordance with the insurer's table of
2138 premium rates applicable to the age and class of risk of the persons to be covered and to the
2139 type and amount of coverage provided. If the spouse applies and tenders the first monthly
2140 premium to the insurer within 30 days after receiving the notice provided by this Subsection
2141 (3), the spouse shall receive individual coverage that commences immediately upon
2142 termination of coverage under the insured's policy.
2143 (4) This section does not apply to accident and health insurance policies offered on a
2144 group blanket basis or a health benefit plan.
2145 Section 11. Section **31A-22-618.6** is amended to read:
2146 **31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit**
2147 **plans.**
2148 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
2149 sponsor is renewable and continues in force:
2150 (a) with respect to all eligible employees and dependents; and
2151 (b) at the option of the plan sponsor.
2152 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:
2153 (a) for noncompliance with the insurer's employer contribution requirements;
2154 (b) if there is no longer any enrollee under the group health plan who lives, resides, or
2155 works in:
2156 (i) the service area of the insurer; or
2157 (ii) the area for which the insurer is authorized to do business;
2158 (c) for coverage made available in the small or large employer market only through an
2159 association, if:
2160 (i) the employer's membership in the association ceases; and
2161 (ii) the coverage is terminated uniformly without regard to any health status-related
2162 factor relating to any covered individual; or
2163 (d) for noncompliance with the insurer's minimum employee participation
2164 requirements, except as provided in Subsection (3).

2165 (3) If a small employer [employs fewer than two eligible employees] no longer
2166 employs at least one eligible employee, a carrier may not discontinue or not renew the health
2167 benefit plan until the first renewal date following the beginning of a new plan year, even if the
2168 carrier knows at the beginning of the plan year that the employer no longer has at least [two
2169 current employees] one eligible employee.
2170 (4) (a) A small employer that, after purchasing a health benefit plan in the small group
2171 market, employs on average more than 50 eligible employees on each business day in a
2172 calendar year may continue to renew the health benefit plan purchased in the small group
2173 market.
2174 (b) A large employer that, after purchasing a health benefit plan in the large group
2175 market, employs on average fewer than 51 eligible employees on each business day in a
2176 calendar year may continue to renew the health benefit plan purchased in the large group
2177 market.
2178 (5) A health benefit plan for a plan sponsor may be discontinued if:
2179 (a) a condition described in Subsection (2) exists;
2180 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
2181 terms of the contract;
2182 (c) the plan sponsor:
2183 (i) performs an act or practice that constitutes fraud; or
2184 (ii) makes an intentional misrepresentation of material fact under the terms of the
2185 coverage;
2186 (d) the insurer:
2187 (i) elects to discontinue offering a particular health benefit plan product delivered or
2188 issued for delivery in this state; and
2189 (ii) (A) provides notice of the discontinuation in writing to each plan sponsor,
2190 employee, or dependent of a plan sponsor or an employee, at least 90 days before the date the
2191 coverage will be discontinued;
2192 (B) provides notice of the discontinuation in writing to the commissioner, and at least
2193 three working days before the date the notice is sent to the affected plan sponsors, employees,
2194 and dependents of the plan sponsors or employees;
2195 (C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all

2196 other health benefit plans currently being offered by the insurer in the market or, in the case of
2197 a large employer, any other health benefit plans currently being offered in that market; and
2198 (D) in exercising the option to discontinue that health benefit plan and in offering the
2199 option of coverage in this section, acts uniformly without regard to the claims experience of a
2200 plan sponsor, any health status-related factor relating to any covered participant or beneficiary,
2201 or any health status-related factor relating to any new participant or beneficiary who may
2202 become eligible for the coverage; or
2203 (e) the insurer:
2204 (i) elects to discontinue all of the insurer's health benefit plans in:
2205 (A) the small employer market;
2206 (B) the large employer market; or
2207 (C) both the small employer and large employer markets; and
2208 (ii) (A) provides notice of the discontinuation in writing to each plan sponsor,
2209 employee, or dependent of a plan sponsor or an employee at least 180 days before the date the
2210 coverage will be discontinued;
2211 (B) provides notice of the discontinuation in writing to the commissioner in each state
2212 in which an affected insured individual is known to reside and, at least 30 working days before
2213 the date the notice is sent to the affected plan sponsors, employees, and the dependents of the
2214 plan sponsors or employees;
2215 (C) discontinues and nonrenews all plans issued or delivered for issuance in the market
2216 described in Subsection (5)(e)(i); and
2217 (D) provides a plan of orderly withdrawal as required by Section 31A-4-115.
2218 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be
2219 discontinued if after issuance of coverage the eligible employee:
2220 (i) engages in an act or practice in connection with the coverage that constitutes fraud;
2221 or
2222 (ii) makes an intentional misrepresentation of material fact in connection with the
2223 coverage.
2224 (b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:
2225 (i) 12 months after the date of discontinuance; and
2226 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies

2227 to reenroll.
2228 (c) At the time the eligible employee's coverage is discontinued under Subsection
2229 (6)(a), the insurer shall notify the eligible employee of the right to reenroll when coverage is
2230 discontinued.
2231 (d) An eligible employee may not be discontinued under this Subsection (6) because of
2232 a fraud or misrepresentation that relates to health status.
2233 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to
2234 the employer:
2235 (a) with respect to coverage provided to an employer member of the association; and
2236 (b) if the health benefit plan is made available by an insurer in the employer market
2237 only through:
2238 (i) an association;
2239 (ii) a trust; or
2240 (iii) a discretionary group.
2241 (8) An insurer may modify a health benefit plan for a plan sponsor only:
2242 (a) at the time of coverage renewal; and
2243 (b) if the modification is effective uniformly among all plans with that product.
2244 Section 12. Section **31A-22-629** is amended to read:
2245 **31A-22-629. Adverse benefit determination review process.**
2246 (1) As used in this section:
2247 (a) (i) "Adverse benefit determination" means the:
2248 (A) denial of a benefit;
2249 (B) reduction of a benefit;
2250 (C) termination of a benefit; or
2251 (D) failure to provide or make payment, in whole or in part, for a benefit.
2252 (ii) "Adverse benefit determination" includes:
2253 (A) denial, reduction, termination, or failure to provide or make payment that is based
2254 on a determination of an insured's or a beneficiary's eligibility to participate in a plan;
2255 (B) denial, reduction, or termination of, or a failure to provide or make payment, in
2256 whole or in part, for, a benefit resulting from the application of a utilization review; or
2257 (C) failure to cover an item or service for which benefits are otherwise provided

2258 because it is determined to be:
2259 (I) experimental;
2260 (II) investigational; or
2261 (III) not medically necessary or appropriate.
2262 (b) "Independent review" means a process that:
2263 (i) is a voluntary option for the resolution of an adverse benefit determination;
2264 (ii) is conducted at the discretion of the claimant;
2265 (iii) is conducted by an independent review organization designated by the [~~insurer~~]
2266 commissioner;
2267 (iv) renders an independent and impartial decision on an adverse benefit determination
2268 submitted by an insured; and
2269 (v) may not require the insured to pay a fee for requesting the independent review.
2270 (c) "Independent review organization" means a person, subject to Subsection (6), who
2271 conducts an independent external review of adverse determinations.
2272 (d) "Insured" is as defined in Section 31A-1-301 and includes a person who is
2273 authorized to act on the insured's behalf.
2274 (e) "Insurer" is as defined in Section 31A-1-301 and includes:
2275 (i) a health maintenance organization; and
2276 (ii) a third party administrator that offers, sells, manages, or administers a health
2277 insurance policy or health maintenance organization contract that is subject to this title.
2278 (f) "Internal review" means the process an insurer uses to review an insured's adverse
2279 benefit determination before the adverse benefit determination is submitted for independent
2280 review.
2281 (2) This section applies generally to health insurance policies, health maintenance
2282 organization contracts, and income replacement or disability income policies.
2283 (3) (a) An insured may submit an adverse benefit determination to the insurer.
2284 (b) The insurer shall conduct an internal review of the insured's adverse benefit
2285 determination.
2286 (c) An insured who disagrees with the results of an internal review may submit the
2287 adverse benefit determination for an independent review if the adverse benefit determination
2288 involves:

2289 (i) payment of a claim regarding medical necessity; or
2290 (ii) denial of a claim regarding medical necessity.
2291 (4) The commissioner shall adopt rules that establish minimum standards for:
2292 (a) internal reviews;
2293 (b) independent reviews to ensure independence and impartiality;
2294 (c) the types of adverse benefit determinations that may be submitted to an independent
2295 review; and
2296 (d) the timing of the review process, including an expedited review when medically
2297 necessary.
2298 (5) Nothing in this section may be construed as:
2299 (a) expanding, extending, or modifying the terms of a policy or contract with respect to
2300 benefits or coverage;
2301 (b) permitting an insurer to charge an insured for the internal review of an adverse
2302 benefit determination;
2303 (c) restricting the use of arbitration in connection with or subsequent to an independent
2304 review; or
2305 (d) altering the legal rights of any party to seek court or other redress in connection
2306 with:
2307 (i) an adverse decision resulting from an independent review, except that if the insurer
2308 is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the
2309 insured related to the action and court costs; or
2310 (ii) an adverse benefit determination or other claim that is not eligible for submission
2311 to independent review.
2312 (6) (a) An independent review organization in relation to the insurer may not be:
2313 (i) the insurer;
2314 (ii) the health plan;
2315 (iii) the health plan's fiduciary;
2316 (iv) the employer; or
2317 (v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).
2318 (b) An independent review organization may not have a material professional, familial,
2319 or financial conflict of interest with:

2320 (i) the health plan;
2321 (ii) an officer, director, or management employee of the health plan;
2322 (iii) the enrollee;
2323 (iv) the enrollee's health care provider;
2324 (v) the health care provider's medical group or independent practice association;
2325 (vi) a health care facility where service would be provided; or
2326 (vii) the developer or manufacturer of the service that would be provided.
2327 Section 13. Section **31A-22-701** is amended to read:
2328 **31A-22-701. Groups eligible for group or blanket insurance.**
2329 (1) As used in this section, "association group" means a lawfully formed association of
2330 individuals or business entities that:
2331 (a) purchases insurance on a group basis on behalf of members; and
2332 (b) is formed and maintained in good faith for purposes other than obtaining insurance.
2333 (2) A group accident and health insurance policy may be issued to:
2334 (a) a group:
2335 (i) to which a group life insurance policy may be issued under [~~Sections~~] Section
2336 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-506, or 31A-22-507[~~, and 31A-22-509~~]; and
2337 (ii) that is formed and maintained in good faith for a purpose other than obtaining
2338 insurance;
2339 (b) an association group authorized by the commissioner that:
2340 (i) has been actively in existence for at least five years;
2341 (ii) has a constitution and bylaws;
2342 (iii) has a shared or common purpose that is not primarily a business or customer
2343 relationship;
2344 (iv) is formed and maintained in good faith for purposes other than obtaining
2345 insurance;
2346 (v) does not condition membership in the association group on any health status-related
2347 factor relating to an individual, including an employee of an employer or a dependent of an
2348 employee;
2349 (vi) makes accident and health insurance coverage offered through the association
2350 group available to all members regardless of any health status-related factor relating to the

2351 members or individuals eligible for coverage through a member;
2352 (vii) does not make accident and health insurance coverage offered through the
2353 association group available other than in connection with a member of the association group;
2354 and
2355 (viii) is actuarially sound; or
2356 (c) a group specifically authorized by the commissioner [~~under Section 31A-22-509~~],
2357 upon a finding that:
2358 (i) authorization is not contrary to the public interest;
2359 (ii) the group is actuarially sound;
2360 (iii) formation of the proposed group may result in economies of scale in acquisition,
2361 administrative, marketing, and brokerage costs;
2362 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be
2363 offered to the proposed group is substantially equivalent to insurance policies that are
2364 otherwise available to similar groups;
2365 (v) the group would not present hazards of adverse selection;
2366 (vi) the premiums for the insurance policy and any contributions by or on behalf of the
2367 insured persons are reasonable in relation to the benefits provided; and
2368 (vii) the group is formed and maintained in good faith for a purpose other than
2369 obtaining insurance.
2370 (3) A blanket accident and health insurance policy:
2371 (a) covers a defined class of persons;
2372 (b) may not be offered or underwritten on an individual basis;
2373 (c) shall cover only a group that is:
2374 (i) actuarially sound; and
2375 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;
2376 and
2377 (d) may be issued only to:
2378 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as
2379 policyholder, covering persons who may become passengers as defined by reference to the
2380 person's travel status;
2381 (ii) an employer, as policyholder, covering any group of employees, dependents, or

2382 guests, as defined by reference to specified hazards incident to any activities of the
2383 policyholder;
2384 (iii) an institution of learning, including a school district, a school jurisdictional unit, or
2385 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering
2386 students, teachers, or employees;
2387 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of
2388 one of those organizations, as policyholder, covering a group of members or participants as
2389 defined by reference to specified hazards incident to the activities sponsored or supervised by
2390 the policyholder;
2391 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering
2392 members, campers, employees, officials, or supervisors;
2393 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer
2394 organization, as policyholder, covering a group of members or participants as defined by
2395 reference to specified hazards incident to activities sponsored, supervised, or participated in by
2396 the policyholder;
2397 (vii) a newspaper or other publisher, as policyholder, covering its carriers;
2398 (viii) an association, including a labor union, that has a constitution and bylaws and
2399 that is organized in good faith for purposes other than that of obtaining insurance, as
2400 policyholder, covering a group of members or participants as defined by reference to specified
2401 hazards incident to the activities or operations sponsored or supervised by the policyholder; and
2402 (ix) any other class of risks that, in the judgment of the commissioner, may be properly
2403 eligible for blanket accident and health insurance.
2404 (4) The judgment of the commissioner may be exercised on the basis of:
2405 (a) individual risks;
2406 (b) a class of risks; or
2407 (c) both Subsections (4)(a) and (b).
2408 Section 14. Section **31A-22-722** is amended to read:
2409 **31A-22-722. Utah mini-COBRA benefits for employer group coverage.**
2410 (1) An insured may extend the employee's coverage under the current employer's group
2411 policy for a period of 12 months, except as provided in [~~Subsections (2) and 31A-22-722.5(4)~~]
2412 Subsection (2). The right to extend coverage includes:

2413 (a) voluntary termination;
2414 (b) involuntary termination;
2415 (c) retirement;
2416 (d) death;
2417 (e) divorce or legal separation;
2418 (f) loss of dependent status;
2419 (g) sabbatical;
2420 (h) a disability;
2421 (i) leave of absence; or
2422 (j) reduction of hours.
2423 (2) (a) Notwithstanding Subsection (1), an employee may not extend coverage under
2424 the current employer's group insurance policy if the employee:
2425 (i) fails to pay premiums or contributions in accordance with the terms of the insurance
2426 policy;
2427 (ii) acquires other group coverage covering all preexisting conditions including
2428 maternity, if the coverage exists;
2429 (iii) performs an act or practice that constitutes fraud in connection with the coverage;
2430 (iv) makes an intentional misrepresentation of material fact under the terms of the
2431 coverage;
2432 (v) is terminated from employment for gross misconduct;
2433 (vi) is not continuously covered under the current employer's group policy for a period
2434 of three months immediately before the termination of the insurance policy due to an event set
2435 forth in Subsection (1);
2436 (vii) is eligible for an extension of coverage required by federal law;
2437 (viii) establishes residence outside of this state;
2438 (ix) moves out of the insurer's service area;
2439 (x) is eligible for similar coverage under another group insurance policy; or
2440 (xi) has the employee's coverage terminated because the employer's coverage is
2441 terminated, except as provided in Subsection (8).
2442 (b) The right to extend coverage under Subsection (1) applies to spouse or dependent
2443 coverage, including a surviving spouse or dependents whose coverage under the insurance

2444 policy terminates by reason of the death of the employee or member.
2445 (3) (a) The employer shall notify the following in writing of the right to extend group
2446 coverage and the payment amounts required for extension of coverage, including the manner,
2447 place, and time in which the payments shall be made:
2448 (i) a terminated insured;
2449 (ii) an ex-spouse of an insured; or
2450 (iii) if Subsection (2)(b) applies:
2451 (A) a surviving spouse; and
2452 (B) the guardian of surviving dependents, if different from a surviving spouse.
2453 (b) The notification required in Subsection (3)(a) shall be sent first class mail within 30
2454 days after the termination date of the group coverage to:
2455 (i) the terminated insured's home address as shown on the records of the employer;
2456 (ii) the address of the surviving spouse, if different from the insured's address and if
2457 shown on the records of the employer;
2458 (iii) the guardian of any dependents address, if different from the insured's address, and
2459 if shown on the records of the employer; and
2460 (iv) the address of the ex-spouse, if shown on the records of the employer.
2461 (4) The insurer shall provide the employee, spouse, or any eligible dependent the
2462 opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:
2463 (a) the employer policyholder does not provide the terminated insured the written
2464 notification required by Subsection (3)(a); and
2465 (b) the employee or other individual eligible for extension contacts the insurer within
2466 60 days of coverage termination.
2467 (5) (a) A premium amount for extended group coverage may not exceed 102% of the
2468 group rate in effect for a group member, including an employer's contribution, if any, for a
2469 group insurance policy.
2470 (b) An insurer may not charge an insured an additional fee, an additional premium,
2471 interest, or any similar charge for electing extended group coverage.
2472 (6) Except as provided in this Subsection (6), coverage extends without interruption for
2473 12 months and may not terminate if the terminated insured or, with respect to a minor, the
2474 parent or guardian of the terminated insured:

2475 (a) elects to extend group coverage within 60 days of losing group coverage; and
2476 (b) tenders the amount required to the employer or insurer.
2477 (7) The insured's coverage may be terminated before 12 months if the terminated
2478 insured:
2479 (a) establishes residence outside of this state;
2480 (b) moves out of the insurer's service area;
2481 (c) fails to pay premiums or contributions in accordance with the terms of the insurance
2482 policy, including any timeliness requirements;
2483 (d) performs an act or practice that constitutes fraud in connection with the coverage;
2484 (e) makes an intentional misrepresentation of material fact under the terms of the
2485 coverage;
2486 (f) becomes eligible for similar coverage under another group insurance policy; or
2487 (g) has the coverage terminated because the employer's coverage is terminated, except
2488 as provided in Subsection (8).
2489 (8) If the current employer coverage is terminated and the employer replaces coverage
2490 with similar coverage under another group insurance policy, without interruption, the
2491 terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection
2492 (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:
2493 (a) for the balance of the period the terminated insured would have extended coverage
2494 under the replaced group insurance policy; and
2495 (b) if the terminated insured is otherwise eligible for extension of coverage.
2496 (9) An insurer shall require an insured employer to offer to the following individuals an
2497 open enrollment period at the same time as other regular employees:
2498 (a) an individual who extends group coverage and is current on payment; and
2499 (b) during the applicable grace period described in Subsection (3) or (4), an individual
2500 who is eligible to elect to extend group coverage.
2501 Section 15. Section **31A-23a-107** is amended to read:
2502 **31A-23a-107. Character requirements.**
2503 An applicant for a license under this chapter shall show to the commissioner that:
2504 (1) the applicant has the intent in good faith, to engage in the type of business that the
2505 license applied for would permit;

2506 (2) (a) if a natural person, the applicant is:
2507 (i) competent; and
2508 (ii) trustworthy; or
2509 (b) if the applicant is an agency:
2510 (i) the partners, directors, or principal officers or persons having comparable powers
2511 are trustworthy; and
2512 (ii) that it will transact business in such a way that the acts that may only be performed
2513 by a licensed producer, surplus lines producer, limited line producer, consultant, managing
2514 general agent, or reinsurance intermediary are performed exclusively by natural persons who
2515 are licensed under this chapter to transact that type of business and designated on the agency's
2516 license;
2517 (3) the applicant intends to comply with Section 31A-23a-502; and
2518 (4) if a natural person, the applicant is at least 18 years of age.
2519 Section 16. Section **31A-23a-109** is amended to read:
2520 **31A-23a-109. Nonresident jurisdictional agreement.**
2521 (1) (a) If a nonresident license applicant has a valid producer, surplus lines producer,
2522 limited line producer, consultant, managing general agent, or reinsurance intermediary license
2523 from the nonresident license applicant's home state or designated home state and the conditions
2524 of Subsection (1)(b) are met, the commissioner shall:
2525 (i) waive the license requirements for a license under this chapter; and
2526 (ii) issue the nonresident license applicant a nonresident license.
2527 (b) Subsection (1)(a) applies if:
2528 (i) the nonresident license applicant:
2529 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or
2530 designated home state at the time the nonresident license applicant applies for a nonresident
2531 producer, surplus lines producer, limited line producer, consultant, managing general agent, or
2532 reinsurance intermediary license;
2533 (B) has submitted the proper request for licensure;
2534 (C) has submitted to the commissioner:
2535 (I) the application for licensure that the nonresident license applicant submitted to the
2536 applicant's home state or designated home state; or

2537 (II) a completed uniform application; and
2538 (D) has paid the applicable fees under Section 31A-3-103; and
2539 (ii) the nonresident license applicant's license in the applicant's home state or
2540 designated home state is in good standing.
2541 (2) A nonresident applicant applying under Subsection (1) shall in addition to
2542 complying with all license requirements for a license under this chapter execute, in a form
2543 acceptable to the commissioner, an agreement to be subject to the jurisdiction of the Utah
2544 commissioner and courts on any matter related to the applicant's insurance activities in this
2545 state, on the basis of:
2546 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
2547 (b) service authorized:
2548 (i) in the Utah Rules of Civil Procedure; or
2549 (ii) under Section 78B-3-206.
2550 (3) The commissioner may verify a producer's licensing status through the producer
2551 database maintained by:
2552 (a) the National Association of Insurance Commissioners; or
2553 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
2554 (4) The commissioner may not assess a greater fee for an insurance license or related
2555 service to a person not residing in this state solely on the fact that the person does not reside in
2556 this state.
2557 Section 17. Section **31A-23a-111** is amended to read:
2558 **31A-23a-111. Revoking, suspending, surrendering, lapsing, limiting, or otherwise**
2559 **terminating a license -- Forfeiture -- Rulemaking for renewal or reinstatement.**
2560 (1) A license type issued under this chapter remains in force until:
2561 (a) revoked or suspended under Subsection (5);
2562 (b) surrendered to the commissioner and accepted by the commissioner in lieu of
2563 administrative action;
2564 (c) the licensee dies or is adjudicated incompetent as defined under:
2565 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
2566 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2567 Minors;

2568 (d) lapsed under Section 31A-23a-113; or
2569 (e) voluntarily surrendered.
2570 (2) The following may be reinstated within one year after the day on which the license
2571 is no longer in force:
2572 (a) a lapsed license; or
2573 (b) a voluntarily surrendered license, except that a voluntarily surrendered license may
2574 not be reinstated after the license period in which the license is voluntarily surrendered.
2575 (3) Unless otherwise stated in a written agreement for the voluntary surrender of a
2576 license, submission and acceptance of a voluntary surrender of a license does not prevent the
2577 department from pursuing additional disciplinary or other action authorized under:
2578 (a) this title; or
2579 (b) rules made under this title in accordance with Title 63G, Chapter 3, Utah
2580 Administrative Rulemaking Act.
2581 (4) A line of authority issued under this chapter remains in force until:
2582 (a) the qualifications pertaining to a line of authority are no longer met by the licensee;
2583 or
2584 (b) the supporting license type:
2585 (i) is revoked or suspended under Subsection (5);
2586 (ii) is surrendered to the commissioner and accepted by the commissioner in lieu of
2587 administrative action;
2588 (iii) lapses under Section 31A-23a-113; or
2589 (iv) is voluntarily surrendered; or
2590 (c) the licensee dies or is adjudicated incompetent as defined under:
2591 (i) Title 75, Chapter 5, Part 3, Guardians of Incapacitated Persons; or
2592 (ii) Title 75, Chapter 5, Part 4, Protection of Property of Persons Under Disability and
2593 Minors.
2594 (5) (a) If the commissioner makes a finding under Subsection (5)(b), as part of an
2595 adjudicative proceeding under Title 63G, Chapter 4, Administrative Procedures Act, the
2596 commissioner may:
2597 (i) revoke:
2598 (A) a license; or

2599 (B) a line of authority;
2600 (ii) suspend for a specified period of 12 months or less:
2601 (A) a license; or
2602 (B) a line of authority;
2603 (iii) limit in whole or in part:
2604 (A) a license; or
2605 (B) a line of authority;
2606 (iv) deny a license application;
2607 (v) assess a forfeiture under Subsection 31A-2-308(1)(b)(i) or (1)(c)(i); or
2608 (vi) take a combination of actions under Subsections (5)(a)(i) through (iv) and
2609 Subsection (5)(a)(v).
2610 (b) The commissioner may take an action described in Subsection (5)(a) if the
2611 commissioner finds that the licensee:
2612 (i) is unqualified for a license or line of authority under Section 31A-23a-104,
2613 31A-23a-105, or 31A-23a-107;
2614 (ii) violates:
2615 (A) an insurance statute;
2616 (B) a rule that is valid under Subsection 31A-2-201(3); or
2617 (C) an order that is valid under Subsection 31A-2-201(4);
2618 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other
2619 delinquency proceedings in any state;
2620 (iv) fails to pay a final judgment rendered against the person in this state within 60
2621 days after the day on which the judgment became final;
2622 (v) fails to meet the same good faith obligations in claims settlement that is required of
2623 admitted insurers;
2624 (vi) is affiliated with and under the same general management or interlocking
2625 directorate or ownership as another insurance producer that transacts business in this state
2626 without a license;
2627 (vii) refuses:
2628 (A) to be examined; or
2629 (B) to produce its accounts, records, and files for examination;

2630 (viii) has an officer who refuses to:
2631 (A) give information with respect to the insurance producer's affairs; or
2632 (B) perform any other legal obligation as to an examination;
2633 (ix) provides information in the license application that is:
2634 (A) incorrect;
2635 (B) misleading;
2636 (C) incomplete; or
2637 (D) materially untrue;
2638 (x) violates an insurance law, valid rule, or valid order of another regulatory agency in
2639 any jurisdiction;
2640 (xi) obtains or attempts to obtain a license through misrepresentation or fraud;
2641 (xii) improperly withholds, misappropriates, or converts money or properties received
2642 in the course of doing insurance business;
2643 (xiii) intentionally misrepresents the terms of an actual or proposed:
2644 (A) insurance contract;
2645 (B) application for insurance; or
2646 (C) life settlement;
2647 (xiv) is convicted of:
2648 (A) a felony; or
2649 (B) a misdemeanor involving fraud, misrepresentation, theft, or dishonesty;
2650 (xv) admits or is found to have committed an insurance unfair trade practice or fraud;
2651 (xvi) in the conduct of business in this state or elsewhere:
2652 (A) uses fraudulent, coercive, or dishonest practices; or
2653 (B) demonstrates incompetence, untrustworthiness, or financial irresponsibility;
2654 (xvii) has an insurance license, or its equivalent, denied, suspended, or revoked in
2655 another state, province, district, or territory;
2656 (xviii) forges another's name to:
2657 (A) an application for insurance; or
2658 (B) a document related to an insurance transaction;
2659 (xix) improperly uses notes or another reference material to complete an examination
2660 for an insurance license;

2661 (xx) knowingly accepts insurance business from an individual who is not licensed;
2662 (xxi) fails to comply with an administrative or court order imposing a child support
2663 obligation;
2664 (xxii) fails to:
2665 (A) pay state income tax; or
2666 (B) comply with an administrative or court order directing payment of state income
2667 tax;
2668 (xxiii) violates or permits others to violate the federal Violent Crime Control and Law
2669 Enforcement Act of 1994, 18 U.S.C. Sec. 1033 and therefore under 18 U.S.C. Sec. 1033 is
2670 prohibited from engaging in the business of insurance; or
2671 (xxiv) engages in a method or practice in the conduct of business that endangers the
2672 legitimate interests of customers and the public.
2673 (c) For purposes of this section, if a license is held by an agency, both the agency itself
2674 and any individual designated under the license are considered to be the holders of the license.
2675 (d) If an individual designated under the agency license commits an act or fails to
2676 perform a duty that is a ground for suspending, revoking, or limiting the individual's license,
2677 the commissioner may suspend, revoke, or limit the license of:
2678 (i) the individual;
2679 (ii) the agency, if the agency:
2680 (A) is reckless or negligent in its supervision of the individual; or
2681 (B) knowingly participates in the act or failure to act that is the ground for suspending,
2682 revoking, or limiting the license; or
2683 (iii) (A) the individual; and
2684 (B) the agency if the agency meets the requirements of Subsection (5)(d)(ii).
2685 (6) A licensee under this chapter is subject to the penalties for acting as a licensee
2686 without a license if:
2687 (a) the licensee's license is:
2688 (i) revoked;
2689 (ii) suspended;
2690 (iii) limited;
2691 (iv) surrendered in lieu of administrative action;

2692 (v) lapsed; or
2693 (vi) voluntarily surrendered; and
2694 (b) the licensee:
2695 (i) continues to act as a licensee; or
2696 (ii) violates the terms of the license limitation.
2697 (7) A licensee under this chapter shall immediately report to the commissioner:
2698 (a) a revocation, suspension, or limitation of the person's license in another state, the
2699 District of Columbia, or a territory of the United States;
2700 (b) the imposition of a disciplinary sanction imposed on that person by another state,
2701 the District of Columbia, or a territory of the United States; or
2702 (c) a judgment or injunction entered against that person on the basis of conduct
2703 involving:
2704 (i) fraud;
2705 (ii) deceit;
2706 (iii) misrepresentation; or
2707 (iv) a violation of an insurance law or rule.
2708 (8) (a) An order revoking a license under Subsection (5) or an agreement to surrender a
2709 license in lieu of administrative action may specify a time, not to exceed five years, within
2710 which the former licensee may not apply for a new license.
2711 (b) If no time is specified in an order or agreement described in Subsection (8)(a), the
2712 former licensee may not apply for a new license for five years from the day on which the order
2713 or agreement is made without the express approval by the commissioner.
2714 (9) The commissioner shall promptly withhold, suspend, restrict, or reinstate the use of
2715 a license issued under this part if so ordered by a court.
2716 (10) The commissioner shall by rule prescribe the license renewal and reinstatement
2717 procedures in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2718 Section 18. Section **31A-23a-208** is amended to read:
2719 **31A-23a-208. Producer and agency authority in health insurance exchange.**
2720 A producer or agency licensed under this chapter, with a line of authority that permits
2721 the producer or agency to sell, negotiate, or solicit accident and health insurance, is authorized
2722 to sell, negotiate, or solicit qualified health plans offered on [~~an~~] a health insurance exchange

2723 [~~that is:~~].
2724 [~~(1) operated in the state; or~~]
2725 [~~(2) operated in the state and certified by the United States Department of Health and~~
2726 ~~Human Services as a:~~]
2727 [~~(a) state-based exchange under PPACA;~~]
2728 [~~(b) a federally facilitated exchange under PPACA; or~~]
2729 [~~(c) a partnership exchange under PPACA.~~]
2730 Section 19. Section **31A-23b-102** is amended to read:
2731 **31A-23b-102. Definitions.**
2732 As used in this chapter:
2733 (1) "Enroll" and "enrollment" mean to:
2734 (a) (i) obtain personally identifiable information about an individual; and
2735 (ii) inform an individual about accident and health insurance plans or public programs
2736 offered on an exchange;
2737 (b) solicit insurance; or
2738 (c) submit to the exchange:
2739 (i) personally identifiable information about an individual; and
2740 (ii) an individual's selection of a particular accident and health insurance plan or public
2741 program offered on the exchange.
2742 [~~(2) (a) "Exchange" means an online marketplace that is certified by the United States~~
2743 ~~Department of Health and Human Services as either a state-based small employer exchange or~~
2744 ~~a federally facilitated individual exchange under PPACA.~~]
2745 [~~(b) "Exchange" does not include an online marketplace for the purchase of health~~
2746 ~~insurance if the online marketplace is not a certified exchange in accordance with Subsection~~
2747 ~~(2)(a).~~]
2748 [~~(3)~~] (2) "Navigator":
2749 (a) means a person who facilitates enrollment in an exchange by offering to assist, or
2750 who advertises any services to assist, with:
2751 (i) the selection of and enrollment in a qualified health plan or a public program
2752 offered on an exchange; or
2753 (ii) applying for premium subsidies through an exchange; and

2754 (b) includes a person who is an in-person assister or a certified application counselor as
2755 described in federal regulations or guidance issued under PPACA.
2756 [(4)] (3) "Personally identifiable information" is as defined in 45 C.F.R. Sec. 155.260.
2757 [(5)] (4) "Public programs" means the state Medicaid program in Title 26, Chapter 18,
2758 Medical Assistance Act, and Title 26, Chapter 40, Utah Children's Health Insurance Act.
2759 [(6)] (5) "Resident" is as defined by rule made by the commissioner in accordance with
2760 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
2761 [(7)] (6) "Solicit" [is as] means the same as that term is defined in Section
2762 31A-23a-102.
2763 Section 20. Section **31A-23b-202.5** is amended to read:
2764 **31A-23b-202.5. License types.**
2765 (1) A license issued under this chapter shall be issued under the license types described
2766 in Subsection (2).
2767 (2) A license type under this chapter shall be a navigator line of authority or a certified
2768 application counselor line of authority. A license type is intended to describe the matters to be
2769 considered under any education, examination, and training required of an applicant under this
2770 chapter.
2771 (3) (a) A navigator line of authority includes the enrollment process as described in
2772 Subsection 31A-23b-102[(3)](2)(a).
2773 (b) (i) A certified application counselor line of authority is limited to providing
2774 information and assistance to individuals and employees about public programs and premium
2775 subsidies available through the exchange.
2776 (ii) A certified application counselor line of authority does not allow the certified
2777 application counselor to assist a person with the selection of or enrollment in a qualified health
2778 plan offered on an exchange.
2779 Section 21. Section **31A-23b-204** is amended to read:
2780 **31A-23b-204. Character requirements.**
2781 An applicant for a license under this chapter shall demonstrate to the commissioner
2782 that:
2783 (1) the applicant has the intent, in good faith, to engage in the practice of a navigator as
2784 the license would permit;

2785 (2) (a) if a natural person, the applicant is:
2786 (i) competent; and
2787 (ii) trustworthy; or
2788 (b) if the applicant is an agency:
2789 (i) the partners, directors, or principal officers or persons having comparable powers
2790 are trustworthy; and
2791 (ii) that it will transact business in a way that the acts that may only be performed by a
2792 licensed navigator are performed only by a natural person who is licensed under this chapter, or
2793 Chapter 23a, Insurance Marketing-Licensing Producers, Consultants, and Reinsurance
2794 Intermediaries;
2795 (3) the applicant intends to comply with the surety bond requirements of Section
2796 31A-23b-207;
2797 (4) if a natural person, the applicant is at least 18 years of age; and
2798 (5) the applicant does not have a conflict of interest as defined by regulations issued
2799 under PPACA.
2800 Section 22. Section **31A-23b-205** is amended to read:
2801 **31A-23b-205. Examination and training requirements.**
2802 (1) The commissioner may require an applicant for a license to pass an examination
2803 and complete a training program as a requirement for a license.
2804 (2) The examination described in Subsection (1) shall reasonably relate to:
2805 (a) the duties and functions of a navigator;
2806 (b) requirements for navigators as established by federal regulation under PPACA; and
2807 (c) other requirements that may be established by the commissioner by administrative
2808 rule.
2809 (3) The examination may be administered by the commissioner or as otherwise
2810 specified by administrative rule.
2811 (4) The training required by Subsection (1) shall be approved by the commissioner and
2812 shall include:
2813 (a) accident and health insurance plans;
2814 (b) qualifications for and enrollment in public programs;
2815 (c) qualifications for and enrollment in premium subsidies;

2816 (d) cultural and linguistic competence;
2817 (e) conflict of interest standards;
2818 (f) exchange functions; and
2819 (g) other requirements that may be adopted by the commissioner by administrative
2820 rule.
2821 (5) (a) For the navigator line of authority, the training required by Subsection (1) shall
2822 consist of at least 21 credit hours of training before obtaining the license, which shall
2823 include[~~:(i) at least two hours of training on defined contribution arrangements and the small~~
2824 ~~employer health insurance exchange; and (ii)~~] the navigator training and certification program
2825 developed by the Centers for Medicare and Medicaid Services.
2826 (b) For the certified application counselor line of authority, the training required by
2827 Subsection (1) shall consist of at least six hours of training before obtaining a license, which
2828 shall include[~~:(i) at least one hour of training on defined contribution arrangements and the~~
2829 ~~small employer health insurance exchange; and(ii)~~] the certified application counselor training
2830 and certification program developed by the Centers for Medicare and Medicaid Services.
2831 (6) This section applies only to an applicant who is a natural person.
2832 Section 23. Section **31A-23b-206** is amended to read:
2833 **31A-23b-206. Continuing education requirements.**
2834 (1) The commissioner shall, by rule, prescribe continuing education requirements for a
2835 navigator.
2836 (2) (a) The commissioner may not require a degree from an institution of higher
2837 education as part of continuing education.
2838 (b) The commissioner may state a continuing education requirement in terms of hours
2839 of instruction received in:
2840 (i) accident and health insurance;
2841 (ii) qualification for and enrollment in public programs;
2842 (iii) qualification for and enrollment in premium subsidies;
2843 (iv) cultural competency;
2844 (v) conflict of interest standards; and
2845 (vi) other exchange functions.
2846 (3) (a) For a navigator line of authority, continuing education requirements shall

2847 require:
2848 (i) that a licensee complete 12 credit hours of continuing education for every one-year
2849 licensing period;
2850 (ii) that at least two of the 12 credit hours described in Subsection (3)(a)(i) be ethics
2851 courses; and
2852 [~~(iii) that at least one of the 12 credit hours described in Subsection (3)(a)(i) be training~~
2853 ~~on defined contribution arrangements and the use of the small employer health insurance~~
2854 ~~exchange; and~~]
2855 [~~(iv)~~] (iii) that a licensee complete the annual navigator training and certification
2856 program developed by the Centers for Medicare and Medicaid Services.
2857 (b) For a certified application counselor, the continuing education requirements shall
2858 require:
2859 (i) that a licensee complete six credit hours of continuing education for every one-year
2860 licensing period;
2861 (ii) that at least two of the six credit hours described in Subsection (3)(b)(i) be on
2862 ethics courses; and
2863 [~~(iii) that at least one of the six credit hours described in Subsection (3)(b)(i) be~~
2864 ~~training on defined contribution arrangements and the use of the small employer health~~
2865 ~~insurance exchange; and~~]
2866 [~~(iv)~~] (iii) that a licensee complete the annual certified application counselor training
2867 and certification program developed by the Centers for Medicare and Medicaid Services.
2868 (c) An hour of continuing education in accordance with Subsections (3)(a)(i) and (b)(i)
2869 may be obtained through:
2870 (i) classroom attendance;
2871 (ii) home study;
2872 (iii) watching a video recording; or
2873 (iv) another method approved by rule.
2874 (d) A licensee may obtain continuing education hours at any time during the one-year
2875 license period.
2876 (e) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
2877 commissioner shall, by rule, authorize one or more continuing education providers, including a

2878 state or national professional producer or consultant associations, to:
2879 (i) offer a qualified program on a geographically accessible basis; and
2880 (ii) collect a reasonable fee for funding and administration of a continuing education
2881 program, subject to the review and approval of the commissioner.
2882 (4) The commissioner shall approve a continuing education provider or a continuing
2883 education course that satisfies the requirements of this section.
2884 (5) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the
2885 commissioner shall by rule establish the procedures for continuing education provider
2886 registration and course approval.
2887 (6) This section applies only to a navigator who is a natural person.
2888 (7) A navigator shall keep documentation of completing the continuing education
2889 requirements of this section for one year after the end of the one-year licensing period to which
2890 the continuing education applies.
2891 Section 24. Section **31A-25-204** is amended to read:
2892 **31A-25-204. Character requirements.**
2893 Each applicant for a license under this chapter shall show to the commissioner all of the
2894 following:
2895 (1) [~~he or it~~] that the applicant has the good faith intent to engage in the type of
2896 business the license applied for would permit;
2897 (2) (a) if a natural person, [~~he is~~] that the applicant is:
2898 (i) competent; and
2899 (ii) trustworthy[~~;~~]; or[~~;~~]
2900 (b) if a partnership or corporation, that all the partners, directors, principal officers, or
2901 persons having comparable powers are trustworthy; and
2902 (3) if a natural person, [~~he~~] that the applicant is at least 18 years of age.
2903 Section 25. Section **31A-25-206** is amended to read:
2904 **31A-25-206. Nonresident jurisdictional agreement.**
2905 (1) (a) If a nonresident license applicant has a valid license from the nonresident license
2906 applicant's home state or designated home state and the conditions of Subsection (1)(b) are
2907 met, the commissioner shall:
2908 (i) waive any license requirement for a license under this chapter; and

2909 (ii) issue the nonresident license applicant a nonresident third party administrator
2910 license.
2911 (b) Subsection (1)(a) applies if:
2912 (i) the nonresident license applicant:
2913 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or
2914 designated home state at the time the nonresident license applicant applies for a nonresident
2915 third party administrator license;
2916 (B) has submitted the proper request for licensure;
2917 (C) has submitted to the commissioner:
2918 (I) the application for licensure that the nonresident license applicant submitted to the
2919 applicant's home state or designated home state; or
2920 (II) a completed uniform application; and
2921 (D) has paid the applicable fees under Section 31A-3-103;
2922 (ii) the nonresident license applicant's license in the applicant's home state or
2923 designated home state is in good standing; and
2924 (iii) the nonresident license applicant's home state or designated home state awards
2925 nonresident third party administrator licenses to residents of this state on the same basis as this
2926 state awards licenses to residents of that home state or designated home state.
2927 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
2928 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter
2929 related to the applicant's insurance activities in Utah, on the basis of:
2930 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
2931 (b) other service authorized in the Utah Rules of Civil Procedure.
2932 (3) The commissioner may verify the third party administrator's licensing status
2933 through the database maintained by:
2934 (a) the National Association of Insurance Commissioners; or
2935 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
2936 (4) The commissioner may not assess a greater fee for an insurance license or related
2937 service to a person not residing in this state based solely on the fact that the person does not
2938 reside in this state.
2939 Section 26. Section **31A-26-102** is amended to read:

2940 **31A-26-102. Definitions.**
2941 As used in this chapter, unless expressly provided otherwise:
2942 (1) "Company adjuster" means a person employed by an insurer [~~whose regular duties~~
2943 ~~include insurance adjusting~~]<u>, or an entity under common control or ownership with the insurer,</u>
2944 <u>who negotiates or settles claims on behalf of the employer</u>.
2945 (2) "Designated home state" means the state or territory of the United States or the
2946 District of Columbia:
2947 (a) in which an insurance adjuster does not maintain the adjuster's principal:
2948 (i) place of residence; or
2949 (ii) place of business;
2950 (b) if the resident state, territory, or District of Columbia of the adjuster does not
2951 license adjusters for the line of authority sought, the adjuster has qualified for the license as if
2952 the person were a resident in the state, territory, or District of Columbia described in
2953 Subsection (2)(a), including an applicable:
2954 (i) examination requirement;
2955 (ii) fingerprint background check requirement; and
2956 (iii) continuing education requirement; and
2957 (c) the adjuster has designated the state, territory, or District of Columbia as the
2958 designated home state.
2959 (3) "Home state" means:
2960 (a) a state or territory of the United States or the District of Columbia in which an
2961 insurance adjuster:
2962 (i) maintains the adjuster's principal:
2963 (A) place of residence; or
2964 (B) place of business; and
2965 (ii) is licensed to act as a resident adjuster; or
2966 (b) if the resident state, territory, or the District of Columbia described in Subsection
2967 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District
2968 of Columbia:
2969 (i) in which the adjuster is licensed;
2970 (ii) in which the adjuster is in good standing; and

2971 (iii) that the adjuster has designated as the adjuster's designated home state.
2972 (4) "Independent adjuster" means an insurance adjuster required to be licensed under
2973 Section 31A-26-201, who engages in insurance adjusting as a representative of one or more
2974 insurers.
2975 (5) "Insurance adjusting" or "adjusting" means directing or conducting the
2976 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an
2977 insurer, policyholder, or a claimant under an insurance policy.
2978 (6) "Organization" means a person other than a natural person, and includes a sole
2979 proprietorship by which a natural person does business under an assumed name.
2980 (7) "Portable electronics insurance" is as defined in Section 31A-22-1802.
2981 (8) "Public adjuster" means a person required to be licensed under Section
2982 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants
2983 under insurance policies.
2984 Section 27. Section **31A-26-205** is amended to read:
2985 **31A-26-205. Character requirements.**
2986 Each applicant for a license under this chapter shall show to the commissioner that:
2987 (1) [~~he~~] the applicant has the good faith intent to engage in the type of business the
2988 license or licenses applied for would permit;
2989 (2) (a) if a natural person, [~~he is~~] the applicant is:
2990 (i) competent; and
2991 (ii) trustworthy[~~,~~]; or[~~ that,~~]
2992 (b) if an organization, all the partners, directors, principal officers, or persons in fact
2993 having comparable powers are trustworthy, and that [~~it~~] the applicant will transact business in
2994 such a way that all acts that may only be performed by a licensed adjuster are performed
2995 exclusively by natural persons who are licensed under this chapter to transact that business and
2996 listed on the organization's license under Section 31A-26-209; and
2997 (3) if a natural person, [~~he~~] the applicant is at least 18 years of age.
2998 Section 28. Section **31A-26-208** is amended to read:
2999 **31A-26-208. Nonresident jurisdictional agreement.**
3000 (1) (a) If a nonresident license applicant has a valid license from the nonresident
3001 license applicant's home state or designated home state and the conditions of Subsection (1)(b)

3002 are met, the commissioner shall:
3003 (i) waive any license requirement for a license under this chapter; and
3004 (ii) issue the nonresident license applicant a nonresident adjuster's license.
3005 (b) Subsection (1)(a) applies if:
3006 (i) the nonresident license applicant:
3007 (A) is licensed [~~as a resident~~] in the nonresident license applicant's home state or
3008 designated home state at the time the nonresident license applicant applies for a nonresident
3009 adjuster license;
3010 (B) has submitted the proper request for licensure;
3011 (C) has submitted to the commissioner:
3012 (I) the application for licensure that the nonresident license applicant submitted to the
3013 applicant's home state or designated home state; or
3014 (II) a completed uniform application; and
3015 (D) has paid the applicable fees under Section 31A-3-103;
3016 (ii) the nonresident license applicant's license in the applicant's home state or
3017 designated home state is in good standing; and
3018 (iii) the nonresident license applicant's home state or designated home state awards
3019 nonresident adjuster licenses to residents of this state on the same basis as this state awards
3020 licenses to residents of that home state or designated home state.
3021 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
3022 agreement to be subject to the jurisdiction of the commissioner and courts of this state on any
3023 matter related to the adjuster's insurance activities in this state, on the basis of:
3024 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
3025 (b) other service authorized under the Utah Rules of Civil Procedure or Section
3026 78B-3-206.
3027 (3) The commissioner may verify an adjuster's licensing status through the database
3028 maintained by:
3029 (a) the National Association of Insurance Commissioners; or
3030 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
3031 (4) The commissioner may not assess a greater fee for an insurance license or related
3032 service to a person not residing in this state based solely on the fact that the person does not

3033 reside in this state.
3034 Section 29. Section **31A-27a-111** is amended to read:
3035 **31A-27a-111. Actions by and against the receiver.**
3036 (1) (a) An allegation by the receiver of improper or fraudulent conduct against a person
3037 may not be the basis of a defense to the enforcement of a contractual obligation owed to the
3038 insurer by a third party.
3039 (b) Notwithstanding Subsection (1)(a), a third party described in this Subsection (1) is
3040 not barred by this section from seeking to establish independently as a defense that the conduct
3041 is materially and substantially related to the contractual obligation for which enforcement is
3042 sought.
3043 (2) (a) Subject to Subsection (2)(b), a prior wrongful or negligent action of any present
3044 or former officer, manager, director, trustee, owner, employee, or agent of the insurer may not
3045 be asserted as a defense to a claim by the receiver:
3046 (i) under a theory of:
3047 (A) estoppel;
3048 (B) comparative fault;
3049 (C) intervening cause;
3050 (D) proximate cause;
3051 (E) reliance; or
3052 (F) mitigation of damages; or
3053 (ii) otherwise.
3054 (b) Notwithstanding Subsection (2)(a):
3055 (i) the affirmative defense of fraud in the inducement may be asserted against the
3056 receiver in a claim based on a contract; and
3057 (ii) a principal under a surety bond or a surety undertaking is entitled to credit against
3058 any reimbursement obligation to the receiver for the value of any property pledged to secure the
3059 reimbursement obligation to the extent that:
3060 (A) the receiver has possession or control of the property; or
3061 (B) the insurer or its agents misappropriated, including commingling, the property.
3062 (c) Evidence of fraud in the inducement is admissible only if it is contained in the
3063 records of the insurer.

3064 (3) Action or inaction by an insurance regulatory authority may not be asserted as a
3065 defense to a claim by the receiver.
3066 (4) (a) Subject to Subsection (4)(b), a judgment or order entered against an insured or
3067 the insurer in contravention of a stay or injunction under this chapter, or at any time by default
3068 or collusion, may not be considered as evidence of liability or of the quantum of damages in
3069 adjudicating claims filed in the estate arising out of the subject matter of the judgment or order.
3070 (b) Subsection (4)(a) does not apply to an affected guaranty association's claim for
3071 amounts paid on a settlement or judgment in pursuit of the affected guaranty association's
3072 statutory obligations.
3073 (5) (a) Subject to Subsection (5)(b), the following do not affect the amount that a
3074 receiver may recover from a third party, regardless of any provision in an agreement to the
3075 contrary:
3076 (i) the insurer's insolvency; or
3077 (ii) the insurer's or receiver's failure to pay all or a portion of an amount or a claim to
3078 the third party.
3079 (b) If an agreement between the insurer and a third party requires a payment by the
3080 insurer before the insurer may recover from the third party, the amount the receiver may
3081 recover from the third party under Subsection (5)(a) is limited to an amount equal to the greater
3082 of:
3083 (i) the amount paid by the insurer or by another person on behalf of the insurer to the
3084 third party; or
3085 (ii) the amount allowed as a claim for payment under:
3086 (A) an approved report described in Section 31A-27a-608;
3087 (B) an order of the receivership court; or
3088 (C) a plan of rehabilitation.
3089 [(5)] (6) The receiver may not be considered a governmental entity for the purposes of
3090 any state law awarding fees to a litigant who prevails against a governmental entity.
3091 Section 30. Section **31A-27a-608** is amended to read:
3092 **31A-27a-608. Liquidator's recommendations to the receivership court.**
3093 (1) The liquidator shall, from time to time as determined by the liquidator, present to
3094 the receivership court for approval, reports of claims settled or determined by the liquidator

3095 under Section 31A-27a-603.
3096 (2) A report required by this section shall include information identifying:
3097 (a) the claim;
3098 (b) the amount of the claim; and
3099 (c) the priority class of the claim.
3100 (3) (a) A claim included in a report described in this section and approved by the
3101 receivership court is a liability of the estate.
3102 (b) An insurer's insolvency does not affect the amount of a liability described in
3103 Subsection (3)(a), regardless of any provision in an agreement to the contrary.
3104 Section 31. Section **31A-43-303** is amended to read:
3105 **31A-43-303. Stop-loss insurance disclosure.**
3106 A stop-loss insurance contract delivered, issued for delivery, or entered into shall
3107 include the disclosure exhibit required by the commissioner through administrative rule, which
3108 shall include at least the following information:
3109 (1) the complete costs for the stop-loss contract;
3110 (2) the date on which the insurance takes effect and terminates, including renewability
3111 provisions;
3112 (3) the aggregate attachment point and the specific attachment point;
3113 (4) limitations on coverage;
3114 (5) an explanation of monthly accommodation and disclosure about any monthly
3115 accommodation features included in the stop-loss contract;
3116 (6) a description of terminal liability funding, including the cost of processing claims
3117 before and after the termination of the contract; [and]
3118 (7) maximum claims liability to the employer[.]; and
3119 (8) a summary of the policy.
3120 Section 32. Section **31A-45-403** is enacted to read:
3121 **31A-45-403. Essential health benefits.**
3122 (1) The state designates the state's own essential health benefits and does not accept a
3123 federal determination of the essential health benefits under the PPACA.
3124 (2) Subject to Subsections (3) and (4), the commissioner shall make rules in
3125 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that designate the

3126 essential health benefits for the state.
3127 (3) Before the commissioner makes rules in accordance with Subsection (2):
3128 (a) the commissioner shall present a summary of the commissioner's planned rules to
3129 the Health Reform Task Force; and
3130 (b) the Health Reform Task Force shall recommend whether the commissioner makes
3131 rules in accordance with the presented summary.
3132 (4) The essential health benefits plan:
3133 (a) may not include a state mandate if the inclusion of the state mandate would require
3134 the state to contribute to premium subsidies under the PPACA; and
3135 (b) may add benefits in addition to the benefits included in a benchmark plan adopted
3136 in accordance with this section if the additional benefits are mandated under the PPACA.
3137 Section 33. Section **63G-2-305** is amended to read:
3138 **63G-2-305. Protected records.**
3139 The following records are protected if properly classified by a governmental entity:
3140 (1) trade secrets as defined in Section 13-24-2 if the person submitting the trade secret
3141 has provided the governmental entity with the information specified in Section 63G-2-309;
3142 (2) commercial information or nonindividual financial information obtained from a
3143 person if:
3144 (a) disclosure of the information could reasonably be expected to result in unfair
3145 competitive injury to the person submitting the information or would impair the ability of the
3146 governmental entity to obtain necessary information in the future;
3147 (b) the person submitting the information has a greater interest in prohibiting access
3148 than the public in obtaining access; and
3149 (c) the person submitting the information has provided the governmental entity with
3150 the information specified in Section 63G-2-309;
3151 (3) commercial or financial information acquired or prepared by a governmental entity
3152 to the extent that disclosure would lead to financial speculations in currencies, securities, or
3153 commodities that will interfere with a planned transaction by the governmental entity or cause
3154 substantial financial injury to the governmental entity or state economy;
3155 (4) records, the disclosure of which could cause commercial injury to, or confer a
3156 competitive advantage upon a potential or actual competitor of, a commercial project entity as

3157 defined in Subsection 11-13-103(4);
3158 (5) test questions and answers to be used in future license, certification, registration,
3159 employment, or academic examinations;
3160 (6) records, the disclosure of which would impair governmental procurement
3161 proceedings or give an unfair advantage to any person proposing to enter into a contract or
3162 agreement with a governmental entity, except, subject to Subsections (1) and (2), that this
3163 Subsection (6) does not restrict the right of a person to have access to, after the contract or
3164 grant has been awarded and signed by all parties, a bid, proposal, application, or other
3165 information submitted to or by a governmental entity in response to:
3166 (a) an invitation for bids;
3167 (b) a request for proposals;
3168 (c) a request for quotes;
3169 (d) a grant; or
3170 (e) other similar document;
3171 (7) information submitted to or by a governmental entity in response to a request for
3172 information, except, subject to Subsections (1) and (2), that this Subsection (7) does not restrict
3173 the right of a person to have access to the information, after:
3174 (a) a contract directly relating to the subject of the request for information has been
3175 awarded and signed by all parties; or
3176 (b) (i) a final determination is made not to enter into a contract that relates to the
3177 subject of the request for information; and
3178 (ii) at least two years have passed after the day on which the request for information is
3179 issued;
3180 (8) records that would identify real property or the appraisal or estimated value of real
3181 or personal property, including intellectual property, under consideration for public acquisition
3182 before any rights to the property are acquired unless:
3183 (a) public interest in obtaining access to the information is greater than or equal to the
3184 governmental entity's need to acquire the property on the best terms possible;
3185 (b) the information has already been disclosed to persons not employed by or under a
3186 duty of confidentiality to the entity;
3187 (c) in the case of records that would identify property, potential sellers of the described

3188 property have already learned of the governmental entity's plans to acquire the property;
3189 (d) in the case of records that would identify the appraisal or estimated value of
3190 property, the potential sellers have already learned of the governmental entity's estimated value
3191 of the property; or
3192 (e) the property under consideration for public acquisition is a single family residence
3193 and the governmental entity seeking to acquire the property has initiated negotiations to acquire
3194 the property as required under Section 78B-6-505;
3195 (9) records prepared in contemplation of sale, exchange, lease, rental, or other
3196 compensated transaction of real or personal property including intellectual property, which, if
3197 disclosed prior to completion of the transaction, would reveal the appraisal or estimated value
3198 of the subject property, unless:
3199 (a) the public interest in access is greater than or equal to the interests in restricting
3200 access, including the governmental entity's interest in maximizing the financial benefit of the
3201 transaction; or
3202 (b) when prepared by or on behalf of a governmental entity, appraisals or estimates of
3203 the value of the subject property have already been disclosed to persons not employed by or
3204 under a duty of confidentiality to the entity;
3205 (10) records created or maintained for civil, criminal, or administrative enforcement
3206 purposes or audit purposes, or for discipline, licensing, certification, or registration purposes, if
3207 release of the records:
3208 (a) reasonably could be expected to interfere with investigations undertaken for
3209 enforcement, discipline, licensing, certification, or registration purposes;
3210 (b) reasonably could be expected to interfere with audits, disciplinary, or enforcement
3211 proceedings;
3212 (c) would create a danger of depriving a person of a right to a fair trial or impartial
3213 hearing;
3214 (d) reasonably could be expected to disclose the identity of a source who is not
3215 generally known outside of government and, in the case of a record compiled in the course of
3216 an investigation, disclose information furnished by a source not generally known outside of
3217 government if disclosure would compromise the source; or
3218 (e) reasonably could be expected to disclose investigative or audit techniques,

3219 procedures, policies, or orders not generally known outside of government if disclosure would
3220 interfere with enforcement or audit efforts;
3221 (11) records the disclosure of which would jeopardize the life or safety of an
3222 individual;
3223 (12) records the disclosure of which would jeopardize the security of governmental
3224 property, governmental programs, or governmental recordkeeping systems from damage, theft,
3225 or other appropriation or use contrary to law or public policy;
3226 (13) records that, if disclosed, would jeopardize the security or safety of a correctional
3227 facility, or records relating to incarceration, treatment, probation, or parole, that would interfere
3228 with the control and supervision of an offender's incarceration, treatment, probation, or parole;
3229 (14) records that, if disclosed, would reveal recommendations made to the Board of
3230 Pardons and Parole by an employee of or contractor for the Department of Corrections, the
3231 Board of Pardons and Parole, or the Department of Human Services that are based on the
3232 employee's or contractor's supervision, diagnosis, or treatment of any person within the board's
3233 jurisdiction;
3234 (15) records and audit workpapers that identify audit, collection, and operational
3235 procedures and methods used by the State Tax Commission, if disclosure would interfere with
3236 audits or collections;
3237 (16) records of a governmental audit agency relating to an ongoing or planned audit
3238 until the final audit is released;
3239 (17) records that are subject to the attorney client privilege;
3240 (18) records prepared for or by an attorney, consultant, surety, indemnitor, insurer,
3241 employee, or agent of a governmental entity for, or in anticipation of, litigation or a judicial,
3242 quasi-judicial, or administrative proceeding;
3243 (19) (a) (i) personal files of a state legislator, including personal correspondence to or
3244 from a member of the Legislature; and
3245 (ii) notwithstanding Subsection (19)(a)(i), correspondence that gives notice of
3246 legislative action or policy may not be classified as protected under this section; and
3247 (b) (i) an internal communication that is part of the deliberative process in connection
3248 with the preparation of legislation between:
3249 (A) members of a legislative body;

3250 (B) a member of a legislative body and a member of the legislative body's staff; or
3251 (C) members of a legislative body's staff; and
3252 (ii) notwithstanding Subsection (19)(b)(i), a communication that gives notice of
3253 legislative action or policy may not be classified as protected under this section;
3254 (20) (a) records in the custody or control of the Office of Legislative Research and
3255 General Counsel, that, if disclosed, would reveal a particular legislator's contemplated
3256 legislation or contemplated course of action before the legislator has elected to support the
3257 legislation or course of action, or made the legislation or course of action public; and
3258 (b) notwithstanding Subsection (20)(a), the form to request legislation submitted to the
3259 Office of Legislative Research and General Counsel is a public document unless a legislator
3260 asks that the records requesting the legislation be maintained as protected records until such
3261 time as the legislator elects to make the legislation or course of action public;
3262 (21) research requests from legislators to the Office of Legislative Research and
3263 General Counsel or the Office of the Legislative Fiscal Analyst and research findings prepared
3264 in response to these requests;
3265 (22) drafts, unless otherwise classified as public;
3266 (23) records concerning a governmental entity's strategy about:
3267 (a) collective bargaining; or
3268 (b) imminent or pending litigation;
3269 (24) records of investigations of loss occurrences and analyses of loss occurrences that
3270 may be covered by the Risk Management Fund, the Employers' Reinsurance Fund, the
3271 Uninsured Employers' Fund, or similar divisions in other governmental entities;
3272 (25) records, other than personnel evaluations, that contain a personal recommendation
3273 concerning an individual if disclosure would constitute a clearly unwarranted invasion of
3274 personal privacy, or disclosure is not in the public interest;
3275 (26) records that reveal the location of historic, prehistoric, paleontological, or
3276 biological resources that if known would jeopardize the security of those resources or of
3277 valuable historic, scientific, educational, or cultural information;
3278 (27) records of independent state agencies if the disclosure of the records would
3279 conflict with the fiduciary obligations of the agency;
3280 (28) records of an institution within the state system of higher education defined in

3281 Section 53B-1-102 regarding tenure evaluations, appointments, applications for admissions,
3282 retention decisions, and promotions, which could be properly discussed in a meeting closed in
3283 accordance with Title 52, Chapter 4, Open and Public Meetings Act, provided that records of
3284 the final decisions about tenure, appointments, retention, promotions, or those students
3285 admitted, may not be classified as protected under this section;
3286 (29) records of the governor's office, including budget recommendations, legislative
3287 proposals, and policy statements, that if disclosed would reveal the governor's contemplated
3288 policies or contemplated courses of action before the governor has implemented or rejected
3289 those policies or courses of action or made them public;
3290 (30) records of the Office of the Legislative Fiscal Analyst relating to budget analysis,
3291 revenue estimates, and fiscal notes of proposed legislation before issuance of the final
3292 recommendations in these areas;
3293 (31) records provided by the United States or by a government entity outside the state
3294 that are given to the governmental entity with a requirement that they be managed as protected
3295 records if the providing entity certifies that the record would not be subject to public disclosure
3296 if retained by it;
3297 (32) transcripts, minutes, or reports of the closed portion of a meeting of a public body
3298 except as provided in Section 52-4-206;
3299 (33) records that would reveal the contents of settlement negotiations but not including
3300 final settlements or empirical data to the extent that they are not otherwise exempt from
3301 disclosure;
3302 (34) memoranda prepared by staff and used in the decision-making process by an
3303 administrative law judge, a member of the Board of Pardons and Parole, or a member of any
3304 other body charged by law with performing a quasi-judicial function;
3305 (35) records that would reveal negotiations regarding assistance or incentives offered
3306 by or requested from a governmental entity for the purpose of encouraging a person to expand
3307 or locate a business in Utah, but only if disclosure would result in actual economic harm to the
3308 person or place the governmental entity at a competitive disadvantage, but this section may not
3309 be used to restrict access to a record evidencing a final contract;
3310 (36) materials to which access must be limited for purposes of securing or maintaining
3311 the governmental entity's proprietary protection of intellectual property rights including patents,

3312 copyrights, and trade secrets;
3313 (37) the name of a donor or a prospective donor to a governmental entity, including an
3314 institution within the state system of higher education defined in Section 53B-1-102, and other
3315 information concerning the donation that could reasonably be expected to reveal the identity of
3316 the donor, provided that:
3317 (a) the donor requests anonymity in writing;
3318 (b) any terms, conditions, restrictions, or privileges relating to the donation may not be
3319 classified protected by the governmental entity under this Subsection (37); and
3320 (c) except for an institution within the state system of higher education defined in
3321 Section 53B-1-102, the governmental unit to which the donation is made is primarily engaged
3322 in educational, charitable, or artistic endeavors, and has no regulatory or legislative authority
3323 over the donor, a member of the donor's immediate family, or any entity owned or controlled
3324 by the donor or the donor's immediate family;
3325 (38) accident reports, except as provided in Sections 41-6a-404, 41-12a-202, and
3326 73-18-13;
3327 (39) a notification of workers' compensation insurance coverage described in Section
3328 34A-2-205;
3329 (40) (a) the following records of an institution within the state system of higher
3330 education defined in Section 53B-1-102, which have been developed, discovered, disclosed to,
3331 or received by or on behalf of faculty, staff, employees, or students of the institution:
3332 (i) unpublished lecture notes;
3333 (ii) unpublished notes, data, and information:
3334 (A) relating to research; and
3335 (B) of:
3336 (I) the institution within the state system of higher education defined in Section
3337 53B-1-102; or
3338 (II) a sponsor of sponsored research;
3339 (iii) unpublished manuscripts;
3340 (iv) creative works in process;
3341 (v) scholarly correspondence; and
3342 (vi) confidential information contained in research proposals;

3343 (b) Subsection (40)(a) may not be construed to prohibit disclosure of public
3344 information required pursuant to Subsection 53B-16-302(2)(a) or (b); and
3345 (c) Subsection (40)(a) may not be construed to affect the ownership of a record;
3346 (41) (a) records in the custody or control of the Office of Legislative Auditor General
3347 that would reveal the name of a particular legislator who requests a legislative audit prior to the
3348 date that audit is completed and made public; and
3349 (b) notwithstanding Subsection (41)(a), a request for a legislative audit submitted to the
3350 Office of the Legislative Auditor General is a public document unless the legislator asks that
3351 the records in the custody or control of the Office of Legislative Auditor General that would
3352 reveal the name of a particular legislator who requests a legislative audit be maintained as
3353 protected records until the audit is completed and made public;
3354 (42) records that provide detail as to the location of an explosive, including a map or
3355 other document that indicates the location of:
3356 (a) a production facility; or
3357 (b) a magazine;
3358 (43) information:
3359 (a) contained in the statewide database of the Division of Aging and Adult Services
3360 created by Section 62A-3-311.1; or
3361 (b) received or maintained in relation to the Identity Theft Reporting Information
3362 System (IRIS) established under Section 67-5-22;
3363 (44) information contained in the Management Information System and Licensing
3364 Information System described in Title 62A, Chapter 4a, Child and Family Services;
3365 (45) information regarding National Guard operations or activities in support of the
3366 National Guard's federal mission;
3367 (46) records provided by any pawn or secondhand business to a law enforcement
3368 agency or to the central database in compliance with Title 13, Chapter 32a, Pawnshop and
3369 Secondhand Merchandise Transaction Information Act;
3370 (47) information regarding food security, risk, and vulnerability assessments performed
3371 by the Department of Agriculture and Food;
3372 (48) except to the extent that the record is exempt from this chapter pursuant to Section
3373 63G-2-106, records related to an emergency plan or program, a copy of which is provided to or

3374 prepared or maintained by the Division of Emergency Management, and the disclosure of
3375 which would jeopardize:
3376 (a) the safety of the general public; or
3377 (b) the security of:
3378 (i) governmental property;
3379 (ii) governmental programs; or
3380 (iii) the property of a private person who provides the Division of Emergency
3381 Management information;
3382 (49) records of the Department of Agriculture and Food that provides for the
3383 identification, tracing, or control of livestock diseases, including any program established under
3384 Title 4, Chapter 24, Utah Livestock Brand and Anti-Theft Act, or Title 4, Chapter 31, Control
3385 of Animal Disease;
3386 (50) as provided in Section 26-39-501:
3387 (a) information or records held by the Department of Health related to a complaint
3388 regarding a child care program or residential child care which the department is unable to
3389 substantiate; and
3390 (b) information or records related to a complaint received by the Department of Health
3391 from an anonymous complainant regarding a child care program or residential child care;
3392 (51) unless otherwise classified as public under Section 63G-2-301 and except as
3393 provided under Section 41-1a-116, an individual's home address, home telephone number, or
3394 personal mobile phone number, if:
3395 (a) the individual is required to provide the information in order to comply with a law,
3396 ordinance, rule, or order of a government entity; and
3397 (b) the subject of the record has a reasonable expectation that this information will be
3398 kept confidential due to:
3399 (i) the nature of the law, ordinance, rule, or order; and
3400 (ii) the individual complying with the law, ordinance, rule, or order;
3401 (52) the name, home address, work addresses, and telephone numbers of an individual
3402 that is engaged in, or that provides goods or services for, medical or scientific research that is:
3403 (a) conducted within the state system of higher education, as defined in Section
3404 53B-1-102; and

3405 (b) conducted using animals;
3406 (53) an initial proposal under Title 63N, Chapter 13, Part 2, Government Procurement
3407 Private Proposal Program, to the extent not made public by rules made under that chapter;
3408 (54) in accordance with Section 78A-12-203, any record of the Judicial Performance
3409 Evaluation Commission concerning an individual commissioner's vote on whether or not to
3410 recommend that the voters retain a judge including information disclosed under Subsection
3411 78A-12-203(5)(e);
3412 (55) information collected and a report prepared by the Judicial Performance
3413 Evaluation Commission concerning a judge, unless Section 20A-7-702 or Title 78A, Chapter
3414 12, Judicial Performance Evaluation Commission Act, requires disclosure of, or makes public,
3415 the information or report;
3416 (56) records contained in the Management Information System created in Section
3417 62A-4a-1003;
3418 (57) records provided or received by the Public Lands Policy Coordinating Office in
3419 furtherance of any contract or other agreement made in accordance with Section 63J-4-603;
3420 (58) information requested by and provided to the 911 Division under Section
3421 63H-7a-302;
3422 (59) in accordance with Section 73-10-33:
3423 (a) a management plan for a water conveyance facility in the possession of the Division
3424 of Water Resources or the Board of Water Resources; or
3425 (b) an outline of an emergency response plan in possession of the state or a county or
3426 municipality;
3427 (60) the following records in the custody or control of the Office of Inspector General
3428 of Medicaid Services, created in Section 63A-13-201:
3429 (a) records that would disclose information relating to allegations of personal
3430 misconduct, gross mismanagement, or illegal activity of a person if the information or
3431 allegation cannot be corroborated by the Office of Inspector General of Medicaid Services
3432 through other documents or evidence, and the records relating to the allegation are not relied
3433 upon by the Office of Inspector General of Medicaid Services in preparing a final investigation
3434 report or final audit report;
3435 (b) records and audit workpapers to the extent they would disclose the identity of a

3436 person who, during the course of an investigation or audit, communicated the existence of any
3437 Medicaid fraud, waste, or abuse, or a violation or suspected violation of a law, rule, or
3438 regulation adopted under the laws of this state, a political subdivision of the state, or any
3439 recognized entity of the United States, if the information was disclosed on the condition that
3440 the identity of the person be protected;
3441 (c) before the time that an investigation or audit is completed and the final
3442 investigation or final audit report is released, records or drafts circulated to a person who is not
3443 an employee or head of a governmental entity for the person's response or information;
3444 (d) records that would disclose an outline or part of any investigation, audit survey
3445 plan, or audit program; or
3446 (e) requests for an investigation or audit, if disclosure would risk circumvention of an
3447 investigation or audit;
3448 (61) records that reveal methods used by the Office of Inspector General of Medicaid
3449 Services, the fraud unit, or the Department of Health, to discover Medicaid fraud, waste, or
3450 abuse;
3451 (62) information provided to the Department of Health or the Division of Occupational
3452 and Professional Licensing under Subsection 58-68-304(3) or (4);
3453 (63) a record described in Section 63G-12-210;
3454 (64) captured plate data that is obtained through an automatic license plate reader
3455 system used by a governmental entity as authorized in Section 41-6a-2003;
3456 (65) any record in the custody of the Utah Office for Victims of Crime relating to a
3457 victim, including:
3458 (a) a victim's application or request for benefits;
3459 (b) a victim's receipt or denial of benefits; and
3460 (c) any administrative notes or records made or created for the purpose of, or used to,
3461 evaluate or communicate a victim's eligibility for or denial of benefits from the Crime Victim
3462 Reparations Fund;
3463 (66) an audio or video recording created by a body-worn camera, as that term is
3464 defined in Section 77-7a-103, that records sound or images inside a hospital or health care
3465 facility as those terms are defined in Section 78B-3-403, inside a clinic of a health care
3466 provider, as that term is defined in Section 78B-3-403, or inside a human service program as

3467 that term is defined in Subsection 62A-2-101(19)(a)(vi), except for recordings that:
3468 (a) depict the commission of an alleged crime;
3469 (b) record any encounter between a law enforcement officer and a person that results in
3470 death or bodily injury, or includes an instance when an officer fires a weapon;
3471 (c) record any encounter that is the subject of a complaint or a legal proceeding against
3472 a law enforcement officer or law enforcement agency;
3473 (d) contain an officer involved critical incident as defined in Subsection
3474 76-2-408(1)(d); or
3475 (e) have been requested for reclassification as a public record by a subject or
3476 authorized agent of a subject featured in the recording; [~~and~~]
3477 (67) a record pertaining to the search process for a president of an institution of higher
3478 education described in Section 53B-2-102, except for application materials for a publicly
3479 announced finalist[~~.~~]; and
3480 (68) work papers as defined in Section 31A-2-204.
3481 Section 34. **Repealer.**
3482 This bill repeals:
3483 Section **31A-22-722.5, Mini-COBRA election -- American Recovery and**
3484 **Reinvestment Act.**
3485 Section **31A-30-209, Insurance producers and the Health Insurance Exchange.**