

State of Arizona
Senate
Fifty-fourth Legislature
Second Regular Session
2020

CHAPTER 61
SENATE BILL 1040

AN ACT

AMENDING SECTION 20-117, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-123; AMENDING SECTIONS 20-239, 20-240, 20-259.01, 20-367.01, 20-866, 20-1108, 20-1241.03, 20-1241.05, 20-1631, 20-1632, 20-1632.01, 20-1653, 20-1654, 20-1656, 20-1674, 20-1676, 20-1677, 20-1678, 20-1694.02, 20-2110, 20-2209, 20-2533, 20-2534, 20-2535, 20-2536, 20-2537, 20-2609 AND 20-2637, ARIZONA REVISED STATUTES; RELATING TO INSURERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-117, Arizona Revised Statutes, is amended to
3 read:

4 20-117. Definitions

5 In this title, unless the context otherwise requires:

6 1. "Health care services organization" has the same meaning
7 prescribed in section 20-1051.

8 2. "Private passenger motor vehicle" means any vehicle that is
9 rated or insured under a family automobile policy, standard automobile
10 policy, personal automobile policy or similar private passenger automobile
11 policy written for personal use, including use by an insured of a motor
12 vehicle in the course of the insured's volunteer work for a tax-exempt
13 organization as described in section 501(c)(3) of the internal revenue
14 code, as opposed to a motor vehicle rated or insured under a commercial
15 automobile policy.

16 3. "SEND", "SENDING" OR "SENT" MEANS TO DELIVER BY UNITED STATES
17 MAIL, PERSONAL DELIVERY OR FAX OR BY ELECTRONIC MEANS CONSISTENT WITH THE
18 REQUIREMENTS OF SECTION 20-239.

19 ~~3.~~ 4. "Volunteer work" means work performed without compensation
20 other than reimbursement of actual expenses incurred, or disbursement of
21 meals or other incidental benefits.

22 Sec. 2. Title 20, chapter 1, article 1, Arizona Revised Statutes,
23 is amended by adding section 20-123, to read:

24 20-123. Sending notices and correspondence

25 FOR THE PURPOSES OF THIS TITLE, IF A NOTICE OR CORRESPONDENCE IS
26 SENT BY:

27 1. MAIL, THE SENDER MUST SEND THE NOTICE OR CORRESPONDENCE TO THE
28 RECIPIENT'S LAST KNOWN MAILING ADDRESS ON FILE WITH THE INSURER.

29 2. ELECTRONIC MEANS, THE SENDER MUST SEND THE NOTICE OR
30 CORRESPONDENCE TO THE RECIPIENT'S LAST KNOWN EMAIL ADDRESS AS PROVIDED BY
31 THE RECIPIENT TO THE INSURER.

32 Sec. 3. Section 20-239, Arizona Revised Statutes, is amended to
33 read:

34 20-239. Electronic communications and records; applicability;
35 definitions

36 A. Any notice to a party or any other document that is required
37 under this title in an insurance transaction or that is to serve as
38 evidence of insurance coverage may be delivered, stored and presented by
39 electronic means if it meets the requirements of title 44, chapter 26,
40 article 1.

41 B. An insurer may deliver a notice or document by electronic means
42 to a party pursuant to this section if the party electronically consents,
43 or confirms consent electronically in advance, to that method of
44 electronic delivery and has not withdrawn consent. An insurer shall

1 obtain distinct advanced electronic consent from the named insured for
2 delivery of any notice under section 20-1632.

3 C. An oral communication or a recording of an oral communication
4 does not qualify as consent for the purposes of this section.

5 D. Notwithstanding subsection A of this section, an insurer ~~issuing~~
6 ~~SENDING~~ a notice pursuant to section 20-1632, subsection A, for a period
7 of five years after the date of the notice, shall maintain in its files
8 verification that the notice was sent by electronic means with a United
9 States postal service electronic postmark or another ~~electronic mail~~ EMAIL
10 delivery service that provides electronic postmarks substantially similar
11 to a United States postal service electronic postmark. The verification
12 must contain sufficient information from which the department may
13 determine that the notice was properly sent.

14 E. An insurer providing notice to an insured ~~pursuant to section~~
15 ~~20-1632~~ by electronic means shall ~~further deliver~~ ALSO SEND that notice to
16 the named insured by United States postal service certified mail,
17 certificate of mailing or first class mail using intelligent MAIL barcode
18 or another similar tracking method used or approved by the United States
19 postal service pursuant to section 20-1632 if either of the following
20 applies:

21 1. The notice being electronically delivered is rejected for
22 delivery or returned to the insurer.

23 2. The insurer becomes aware that the ~~electronic mail~~ EMAIL address
24 provided by the party is no longer valid.

25 F. Delivery of a notice or document pursuant to this section is
26 equivalent to any delivery method required under this title, including
27 delivery by the United States postal service by first class mail, postage
28 prepaid, certified mail, certificate of mailing or first class mail using
29 intelligent MAIL barcode or another similar tracking method used or
30 approved by the United States postal service.

31 G. After the party gives consent, if a change in the hardware or
32 software requirements needed to access or retain a notice or document
33 delivered by electronic means creates a material risk that the party will
34 not be able to access or retain a subsequent notice or document to which
35 the consent applies, the insurer must inform the party of:

36 1. The revised hardware and software requirements for access to and
37 retention of a notice or document delivered by electronic means.

38 2. The party's right to withdraw consent without the imposition of
39 any fee, condition or consequence.

40 H. This section does not affect the requirements related to content
41 or timing of any notice or document required under this title.

42 I. If a provision of this title expressly requires verification or
43 acknowledgment of receipt of a notice or document, the notice or document
44 may be delivered by electronic means only if the method used provides for
45 verification or acknowledgment of receipt.

1 J. The legal effectiveness, validity or enforceability of any
2 insurance contract or policy executed by a party may not be denied solely
3 because the insurer failed to obtain electronic consent or confirmation of
4 consent.

5 K. A party's withdrawal of consent:

6 1. Does not affect the legal effectiveness, validity or
7 enforceability of a notice or document delivered by electronic means to
8 the party before the withdrawal of consent is effective.

9 2. Is effective within seven days after the insurer receives the
10 withdrawal.

11 L. If an insurer fails to comply with subsection G of this section,
12 the party may treat that failure as a withdrawal of consent for the
13 purposes of this section.

14 M. This section does not apply to a notice or document delivered by
15 an insurer in an electronic format before ~~the effective date of this~~
16 ~~section~~ JULY 24, 2014 to a party who, before that date, has consented to
17 receive a notice or document in an electronic format as otherwise provided
18 by law.

19 N. If a party's consent to receive certain notices or documents in
20 an electronic format is on file with an insurer before ~~the effective date~~
21 ~~of this section~~ JULY 24, 2014 and the insurer intends to deliver
22 additional notices or documents to that party in an electronic format
23 pursuant to this section, before delivering the additional notices or
24 documents electronically the insurer must notify the party of both of the
25 following:

26 1. The notices or documents that may be delivered by electronic
27 means under this section that were not previously delivered
28 electronically.

29 2. The party's right to withdraw consent to have notices or
30 documents delivered by electronic means.

31 O. An insurer may not charge a fee to a party who does not consent
32 to receive notices or documents by electronic means and who chooses to
33 receive the notices or documents in hard copy.

34 P. This section applies only to property, casualty and life
35 insurance policies that are subject to this title.

36 Q. This section does not modify, limit or supersede the electronic
37 signatures in global and national commerce act (P.L. 106-229; 15 United
38 States Code ~~section~~ SECTIONS 7001 THROUGH 7031).

39 R. For the purposes of this section:

40 1. "Delivered by electronic means" includes either:

41 (a) The delivery to an ~~e-mail~~ EMAIL address at which a party has
42 consented to receive notices or documents.

43 (b) The posting on an electronic network or site accessible via the
44 internet, ~~OR~~ A mobile application, computer, mobile device, tablet or
45 other electronic device, together with a separate notice of the posting

1 that is provided by ~~electronic mail~~ EMAIL to the ~~e-mail~~ EMAIL address at
2 which the party has consented to receive notice or by any other delivery
3 method that has been consented to by the party.

4 2. "Party" means a recipient of any notice or document as part of
5 an insurance transaction, including an applicant, an insured or a
6 policyholder.

7 Sec. 4. Section 20-240, Arizona Revised Statutes, is amended to
8 read:

9 20-240. Electronic posting of policies; definitions

10 A. Notwithstanding section 20-239, an insurer may post property and
11 casualty insurance policies and endorsements that are subject to article
12 4.1 of this chapter pursuant to section 20-382 on the insurer's website
13 instead of ~~mailing or delivering~~ SENDING the policies and endorsements to
14 the insured, if all of the following conditions are satisfied:

15 1. The policies and endorsements posted by the insurer on its
16 website do not contain personal information or privileged information.

17 2. The insurer makes accessible each policy and endorsement:

18 (a) On the insurer's website while each policy and endorsement
19 remains in use.

20 (b) For a period of five years after the **INSURER DISCONTINUES THE**
21 policy or endorsement ~~is discontinued by the insurer~~.

22 3. The insurer posts its policies and endorsements on the insurer's
23 website in a manner that enables the insured to print and save a copy of
24 the policy and endorsements using programs and applications that are
25 widely available on the internet and free of charge to use.

26 4. The insurer agrees to respond to requests from the insured in a
27 timely manner and to provide notice in the manner that the insurer
28 customarily communicates with an insured:

29 (a) At the time of issuance of the initial policy forms and any
30 renewal forms of a method by which the insured may obtain, on request and
31 without charge, a paper or electronic copy of the insured's policy or
32 endorsement.

33 (b) Of any changes to the forms or endorsements, and of the
34 insured's right to obtain, on request and without charge, a paper or
35 electronic copy of the forms and endorsements.

36 (c) Of the insurer's specific website address and instructions on
37 how to access the referenced policy and endorsement forms on the insurer's
38 website.

39 5. On each declarations page delivered to an insured, the insurer
40 clearly identifies the exact policy and endorsement forms purchased by the
41 insured.

42 B. For the purposes of this section, "personal information" and
43 "privileged information" have the same meanings prescribed in section
44 20-2102.

1 Sec. 5. Section 20-259.01, Arizona Revised Statutes, is amended to
2 read:

3 20-259.01. Motor vehicle liability policy; uninsured
4 optional; underinsured optional; subrogation;
5 medical payments liens; definitions

6 A. Every insurer writing automobile liability or motor vehicle
7 liability policies shall make available to the named insured thereunder
8 and by written notice offer the named insured and at the request of the
9 named insured shall include within the policy uninsured motorist coverage
10 that extends to and covers all persons insured under the policy, in limits
11 not less than the liability limits for bodily injury or death contained
12 within the policy. The offer of limits to a named insured or applicant
13 shall be made ~~at the time of the application~~ on a form approved by the
14 director. An insurance producer that uses such a form in offering
15 uninsured motorist coverage satisfies the insurance producer's standard of
16 care in offering and explaining the nature and applicability of uninsured
17 motorist coverage. The policy declarations page must be sent to the named
18 insured, constitutes the final expression of the named insured's decision
19 to purchase or reject uninsured motorist coverage and is valid for,
20 extends to and covers all persons insured under the policy. An offer form
21 is not required where the named insured purchases such coverage in an
22 amount equal to the limits for bodily injury or death contained in the
23 policy. The offer need not be made in the event of the reinstatement of a
24 lapsed policy or the transfer, substitution, modification or renewal of an
25 existing policy or as a result of a change to the minimum liability limits
26 for bodily injury or death prescribed in section 28-4009. At the request
27 of the named insured, the named insured may purchase and the insurer shall
28 then include within the policy uninsured motorist coverage that extends to
29 and covers all persons insured under the policy in any amount up to the
30 liability limits for bodily injury or death contained within the policy
31 but not less than the limits prescribed in section 28-4009.

32 B. Every insurer writing automobile liability or motor vehicle
33 liability policies shall also make available to the named insured
34 thereunder and shall by written notice offer the named insured and at the
35 request of the named insured shall include within the policy underinsured
36 motorist coverage that extends to and covers all persons insured under the
37 policy, in limits not less than the liability limits for bodily injury or
38 death contained within the policy. The offer of limits to a named insured
39 or applicant shall be made ~~at the time of the application~~ on a form
40 approved by the director. An insurance producer that uses such a form in
41 offering underinsured motorist coverage satisfies the insurance producer's
42 standard of care in offering and explaining the nature and applicability
43 of underinsured motorist coverage. The policy declarations page must be
44 sent to the named insured, constitutes the final expression of the named
45 insured's decision to purchase or reject underinsured motorist coverage

1 and is valid for, extends to and covers all persons insured under the
2 policy. An offer form is not required where the named insured purchases
3 such coverage in an amount equal to the limits for bodily injury or death
4 contained in the policy. The offer need not be made in the event of the
5 reinstatement of a lapsed policy or the transfer, substitution,
6 modification or renewal of an existing policy or as a result of a change
7 to the minimum liability limits for bodily injury or death prescribed in
8 section 28-4009. At the request of the named insured, the named insured
9 may purchase and the insurer shall then include within the policy
10 underinsured motorist coverage that extends to and covers all persons
11 insured under the policy in any amount authorized by the insured up to the
12 liability limits for bodily injury or death contained within the policy.

13 C. Any insurer writing automobile liability or motor vehicle
14 liability policies may make available the coverages required by
15 subsections A and B of this section to owners and operators of motor
16 vehicles that are used as public or livery conveyances or rented to others
17 or that are used in the business primarily to transport property or
18 equipment. Subsections A and B of this section do not preclude an insurer
19 writing automobile liability or motor vehicle liability policies in this
20 state from requiring that all motor vehicles that are owned by or
21 registered to the named insured and that are insured by the same insurer
22 or group of insurers under a common management have the same limits of
23 coverage for uninsured and underinsured motorist coverage in amounts as
24 selected or rejected by the named insured.

25 D. "Uninsured motor vehicles", subject to the terms and conditions
26 of that coverage, includes any insured motor vehicle if the liability
27 insurer of the vehicle is unable to make payment on the liability of its
28 insured, within the limits of the coverage, because of insolvency.

29 E. "Uninsured motorist coverage", subject to the terms and
30 conditions of that coverage, means coverage for damages due to bodily
31 injury or death if the motor vehicle that caused the bodily injury or
32 death is not insured by a motor vehicle liability policy that contains at
33 least the limits prescribed in section 28-4009. For the purposes of
34 uninsured motorist coverage, an uninsured motorist does not include a
35 person who is insured under a motor vehicle liability policy that complies
36 with section 28-4009.

37 F. Any payment made under the bodily injury liability portion of a
38 motor vehicle liability policy insuring the motor vehicle that caused the
39 bodily injury or death in an amount equal to or less than the per person
40 or per occurrence bodily injury limits of that policy, regardless of the
41 number of persons receiving payments, precludes any payment under the
42 uninsured motorist coverage based on the fault of the person who is
43 insured under the motor vehicle liability policy.

1 G. "Underinsured motorist coverage" includes coverage for a person
2 if the sum of the limits of liability under all bodily injury or death
3 liability bonds and liability insurance policies applicable at the time of
4 the accident is less than the total damages for bodily injury or death
5 resulting from the accident. To the extent that the total damages exceed
6 the total applicable liability limits, the underinsured motorist coverage
7 provided in subsection B of this section is applicable to the difference.

8 H. Uninsured and underinsured motorist coverages are separate and
9 distinct and apply to different accident situations. Underinsured
10 motorist coverage shall not provide coverage for a claim against an
11 uninsured motorist in addition to any applicable uninsured motorist
12 coverage. If multiple policies or coverages purchased by one insured on
13 different vehicles apply to an accident or claim, the insurer may limit
14 the coverage so that only one policy or coverage, selected by the insured,
15 shall be applicable to any one accident. If the policy does not contain a
16 statement that informs the insured of the insured's right to select one
17 policy or coverage as required by this subsection, within thirty days
18 after the insurer receives notice of an accident, the insurer shall notify
19 the insured in writing of the insured's right to select one policy or
20 coverage. For the purposes of this subsection, "insurer" includes every
21 insurer within a group of insurers under a common management.

22 I. Insurers that make payments for damages to insureds for
23 uninsured motorist coverage may subrogate and sue for reimbursement of the
24 total amount of the payments in the name of the insured against any
25 uninsured motorist responsible for the damages to the insured.

26 J. Any automobile liability or motor vehicle liability insurer that
27 makes a payment under the medical payments coverage of a motor vehicle
28 insurance policy to or on behalf of any insured for an injury that arises
29 out of an accident that occurs after December 31, 1998 may have a lien
30 against any amount in excess of \$5,000 that is paid to or on behalf of
31 that insured under the medical payments coverage of the policy for that
32 accident. The insurer shall compromise the lien in a fair and equitable
33 manner. In order to perfect a lien granted pursuant to this subsection,
34 within sixty days after issuing a payment that is more than \$5,000 to the
35 insured under medical payments coverage, the insurer or the insurer's
36 authorized representative shall record in the office of the recorder of
37 the county in which the accident occurred a written statement that sets
38 forth the name and address of the insured as they appear in the records of
39 the insurer, the name and address of the insurer at the insurer's
40 principal office in this state, the amount claimed pursuant to this
41 subsection and, to the best of the insurer's knowledge, the names and
42 addresses of all persons, firms and corporations and their insurance
43 carriers that the insured or the insured's legal representative alleges
44 are liable for damages arising from the accident. Within five days after
45 recording the lien, the insurer shall also mail a copy of the lien,

1 postage prepaid, to the insured and to each person, firm and corporation
2 and their insurance carriers alleged to be liable for damages at the
3 address given in the statement. The recording of the lien is notice of
4 the lien to all persons, firms and corporations that are liable for
5 damages regardless of whether they are named in the lien. The recorder
6 shall endorse on the lien recorded pursuant to this subsection the date
7 and hour of receipt and all facts that are necessary to indicate that the
8 lien has been recorded. The lien may be amended to reflect payments to
9 the insured made after the lien is recorded. Within thirty days after the
10 lien is satisfied, the lienholder shall issue and record a release of the
11 lien.

12 K. Any common law prohibition against assignments of causes of
13 action for personal injuries is abrogated to the extent provided in
14 subsection I of this section.

15 L. An insurer is not required to offer, provide or make available
16 coverage conforming to this section in connection with any general
17 commercial liability policy, excess policy, umbrella policy or other
18 policy that does not provide primary motor vehicle insurance for
19 liabilities arising out of the ownership, maintenance, operation or use of
20 a specifically insured motor vehicle.

21 M. If an insured makes a bodily injury or death claim under
22 uninsured or underinsured motorist coverage based on an accident that
23 involved an unidentified motor vehicle and no physical contact with the
24 motor vehicle occurred, the insured shall provide corroboration that the
25 unidentified motor vehicle caused the accident. For the purposes of this
26 subsection, "corroboration" means any additional and confirming testimony,
27 fact or evidence that strengthens and adds weight or credibility to the
28 insured's representation of the accident.

29 Sec. 6. Section 20-367.01, Arizona Revised Statutes, is amended to
30 read:

31 20-367.01. Appeals procedure

32 A. Within a reasonable time after receiving a written request and
33 on payment of a reasonable fee, every rating organization and insurer
34 shall give to any insured affected by a rate that is made or applied by
35 the organization or insurer, or to the insured's authorized
36 representative, all pertinent information related to the rate.

37 B. If a person is aggrieved by the application of a rating system,
38 the person may send a written request to the workers' compensation appeals
39 board established by section 20-367 to review the manner in which the
40 rating system has been applied to the insurance afforded the aggrieved
41 person. The aggrieved person or that person's representative may present
42 the grievance before the board. A representative of the rating
43 organization whose rating system is the subject of the appeal shall attend
44 any hearing before the board pursuant to this section to explain that
45 application of the rating system to the aggrieved person.

1 C. If the board does not act on the aggrieved person's request for
2 review within thirty days after receiving the request, the aggrieved
3 person may proceed as if the board had rejected the request for review.

4 D. The appellant shall pay the cost to record the board's
5 proceedings.

6 E. The board shall ~~mail~~ SEND a written notice of its decision to
7 the aggrieved person. Within thirty days after the date the BOARD SENDS
8 THE written notice of ~~the board's~~ ITS decision ~~is mailed by the board~~, the
9 aggrieved person may appeal the action to the director. After a hearing
10 held on at least ten days' written notice to the person and the rating
11 organization or insurer, the director shall affirm, modify or reverse the
12 board's decision. The person appealing the board's decision shall pay the
13 costs of the transcript and record of the appeal to the director.

14 Sec. 7. Section 20-866, Arizona Revised Statutes, is amended to
15 read:

16 20-866. Location of office; publications; grievance procedure

17 A. The principal office of a domestic society shall be located in
18 this state. The meetings of the society's supreme governing body may be
19 held in any state, district, province or territory in which the society
20 has at least one subordinate lodge or in any other place that is
21 determined by the supreme governing body. Business that is transacted at
22 an out of state meeting is valid in all respects as if the meeting were
23 held in this state. The minutes of the proceedings of the supreme
24 governing body and the board of directors shall be in English.

25 B. A society may publish an official publication in which any
26 notice, report or statement required by the society's laws to be given to
27 its members is published. A required notice, report or statement shall be
28 conspicuously printed in the publication. If the records of the society
29 show that two or more members have the same mailing address, an official
30 publication that is ~~mailed~~ SENT to one member is deemed to be ~~mailed~~ SENT
31 to all members at the same address unless a member requests a separate
32 copy.

33 C. By June 1 of each year, the society shall publish and ~~mail~~ SEND
34 to each benefit member a synopsis of the society's annual statement that
35 explains the condition of the society. The synopsis may be published in
36 the society's official publication.

37 D. A society may establish grievance or complaint procedures by law
38 or rule.

39 Sec. 8. Section 20-1108, Arizona Revised Statutes, is amended to
40 read:

41 20-1108. Admissibility of application as evidence

42 A. ~~No~~ AN application for the issuance of any life or disability
43 insurance policy or contract ~~shall be~~ IS NOT admissible in evidence in any
44 action relative to such policy or contract, unless a true copy of the
45 application was attached to or otherwise made a part of the policy when

1 issued and delivered. This ~~provision shall~~ SUBSECTION DOES not apply to
2 industrial life insurance policies.

3 B. If any policy of life or disability insurance delivered in this
4 state is reinstated or renewed, and the insured or the beneficiary or
5 assignee of the policy makes written request to the insurer for a copy of
6 the application, if any, for such reinstatement or renewal, the insurer
7 ~~shall~~, within thirty days after receipt of the request at its home office
8 or at any of its branch offices, SHALL deliver or ~~mail~~ SEND to the person
9 making the request a copy of the application. If the copy is not ~~so~~
10 delivered or ~~mailed~~ SENT after having been requested, the insurer ~~shall be~~
11 IS precluded from introducing the application in evidence in any action or
12 proceeding based ~~upon~~ ON or involving the policy or its reinstatement or
13 renewal.

14 C. As to kinds of insurance other than life insurance, ~~no~~ AN
15 application for insurance signed by or on behalf of the insured ~~shall be~~
16 IS NOT admissible in evidence in any action between the insured and the
17 insurer arising out of the policy so applied for, if the insurer has
18 failed, at the expiration of thirty days after receipt by the insurer of
19 written demand therefor by or on behalf of the insured, to furnish to the
20 insured a copy of the application reproduced by any legible means.

21 Sec. 9. Section 20-1241.03, Arizona Revised Statutes, is amended to
22 read:

23 20-1241.03. Duties of insurance producers

24 A. An insurance producer who initiates an application shall submit
25 to the insurer, with or as part of the application, a statement signed by
26 both the applicant and the insurance producer as to whether the applicant
27 has an existing policy or contract.

28 B. If the answer is "no" to the question under subsection A of this
29 section regarding existing coverage, the insurance producer has no further
30 replacement duties.

31 C. If the answer is "yes" to the question under subsection A of
32 this section regarding existing coverage, the insurance producer shall
33 present and read to the applicant, not later than the time of taking the
34 application, a notice regarding replacements that is in a form that the
35 director has approved or prescribed by rule.

36 D. The applicant and the insurance producer shall sign the notice
37 required under subsection C of this section. The insurance producer shall
38 leave the signed notice with the applicant. If the notice is presented
39 electronically, the insurer shall ~~mail~~ SEND the applicant a copy of the
40 notice within three business days after the application is submitted to
41 the insurer. In the notice the insurance producer and the applicant shall
42 attest that the insurance producer either read the notice aloud or that
43 the applicant did not wish the notice to be read aloud, in which case the
44 producer need not have read the notice aloud.

1 E. The notice prescribed in subsection C of this section shall:
2 1. Identify each policy and contract proposed to be replaced by:
3 (a) Name of the insurer.
4 (b) Name of the insured or annuitant.
5 (c) Policy or contract number if available.
6 (d) Application or receipt number if the policy or contract number
7 is not available.

8 2. Include a statement as to whether each policy or contract will
9 be replaced or whether a policy will be used as a source of financing for
10 the new policy or contract.

11 F. If the application for a new policy or contract is completed in
12 any replacement transaction, the insurance producer shall give the
13 applicant the original or a copy of all sales material at the time of the
14 application for the new policy or contract. The insurance producer or
15 insurer shall provide the applicant with a printed copy of any
16 electronically presented sales material not later than at the time of
17 policy or contract delivery.

18 G. Except as provided in section 20-1241.05, subsection G, in
19 connection with any replacement transaction, an insurance producer shall
20 submit to the insurer to which an application for a policy or contract is
21 presented a copy of:

- 22 1. Each document required by this section.
23 2. A statement identifying any preprinted or electronically
24 presented company approved sales materials used.
25 3. Any individualized sales materials, including any illustrations
26 related to the specific policy or contract purchased.

27 Sec. 10. Section 20-1241.05, Arizona Revised Statutes, is amended
28 to read:

29 20-1241.05. Duties of replacing insurers that use insurance
30 producers

31 A. A replacing insurer shall comply with the requirements of this
32 section for each replacement transaction.

33 B. The insurer shall verify that it has received all required forms
34 and that the forms comply with this article.

35 C. The insurer shall notify any existing insurer that may be
36 affected by the proposed replacement within five business days ~~of~~ AFTER
37 the receipt of a completed application indicating replacement or, if not
38 indicated on the application, when the replacement is identified, and ~~mail~~
39 SEND a copy of the available illustration or policy summary for the
40 proposed policy or available disclosure document for the proposed contract
41 within five business days ~~of~~ AFTER a request from an existing insurer.

42 D. The insurer shall be able to produce copies of the notification
43 regarding replacement required in section 20-1241.03, subsections C and D,
44 indexed by the insurance producer, for at least five years or until the

1 next regular examination by the insurance regulatory authority of its
2 state of domicile, whichever is later.

3 E. The insurer shall provide the policy or contract owner notice of
4 the right to return the policy or contract within thirty days of delivery
5 and receive an unconditional full refund of all premiums or consideration
6 paid, including any policy fees or charges or, in the case of a variable
7 or market value adjustment policy or contract, a payment of the cash
8 surrender value provided under the policy or contract plus all fees and
9 other charges deducted from the gross premiums or considerations or
10 imposed under the policy or contract. The notice may be included in the
11 notice required under section 20-1241.03, subsections C and D.

12 F. If the replacing insurer and the existing insurer are the same
13 or subsidiaries or affiliates under common ownership or control, the
14 replacing insurer shall allow credit for the period of time that has
15 elapsed under the replacement policy's or contract's incontestability and
16 suicide period up to the face amount of the existing policy or contract.
17 For financed purchases, the insurer may limit the credit to the amount
18 that the face amount of the existing policy is reduced by the use of
19 existing policy values to fund the new policy or contract.

20 G. If an insurer prohibits the use of sales materials the insurer
21 has not approved, the insurer, as an alternative to the requirements of
22 section 20-1241.03, subsection G, may comply as follows:

23 1. The insurer shall require an insurance producer to submit a
24 signed statement with each application stating that the insurance producer
25 used only sales material that the insurer approved and that the insurance
26 producer will provide copies to the applicant as required by section
27 20-1241.03, subsection F.

28 2. Within ten days ~~of~~ AFTER the issuance of the policy or contract,
29 the insurer shall:

30 (a) Notify the applicant by letter or by verbal communication from
31 a person whose duties are separate from the marketing area of the insurer
32 that the insurance producer made the representation about leaving sales
33 materials as described in paragraph 1 OF THIS SUBSECTION.

34 (b) Provide the applicant with a ~~toll-free~~ TOLL-FREE number to
35 contact insurer personnel responsible for regulatory compliance if the
36 insurance producer did not leave sales materials.

37 (c) Advise the applicant that it is important to retain copies of
38 the sales material for future reference.

39 3. The insurer shall be able to produce a copy of the letter or
40 other verification required by paragraph 2, subdivision (a) OF THIS
41 SUBSECTION for at least five years after the termination or expiration of
42 the policy or contract.

1 Sec. 11. Section 20-1631, Arizona Revised Statutes, is amended to
2 read:

3 20-1631. Definition of motor vehicle; cancellation of or
4 failure to renew coverage; limitations; limitation
5 of liability; exceptions; insurance producers;
6 definitions

7 A. In this article, unless the context otherwise requires, "motor
8 vehicle" means a licensed land, motor-driven vehicle but does not mean:

9 1. A private passenger or station wagon type vehicle used as a
10 public or livery conveyance or rented to others.

11 2. Any other four-wheel motor vehicle of a load capacity of fifteen
12 hundred pounds or less that is used in the business of transporting
13 passengers for hire, used in business primarily to transport property or
14 equipment, used as a public or livery conveyance or rented to others.

15 3. Any motor vehicle with a load capacity of more than fifteen
16 hundred pounds.

17 4. ~~From and after February 29, 2016,~~ A vehicle that otherwise
18 qualifies as a motor vehicle under this subsection but only while the
19 driver of the vehicle is logged in to a transportation network company's
20 digital network or software application to be a driver or is providing
21 transportation network services, unless expressly covered by the private
22 passenger policy.

23 B. A motor vehicle used as a public or livery conveyance or rented
24 to others does not include a motor vehicle used in the course of volunteer
25 work for a tax-exempt organization as described in section 501(c)(3) of
26 the internal revenue code.

27 C. An insurer shall not cancel or refuse to renew a motor vehicle
28 insurance policy solely because of the location of residence, age, race,
29 color, religion, sex, national origin or ancestry of anyone who is an
30 insured, except that an insurer may refuse to renew a motor vehicle
31 insurance policy if a named insured establishes a primary residence in a
32 state other than ~~Arizona~~ THIS STATE.

33 D. An insurer shall not issue a motor vehicle insurance policy in
34 this state unless the cancellation and renewal conditions of the policy or
35 the endorsement on the policy includes the limitations required by this
36 section. After a policy issued in this state has been in effect for sixty
37 days, or if the policy is a renewal, effective immediately, the company
38 shall not exercise its right to cancel the insurance afforded under the
39 policy unless:

40 1. The named insured fails to discharge when due any of the
41 obligations of the named insured in connection with the payment of premium
42 for this policy or any installment of the premium.

43 2. The insurance was obtained through fraudulent misrepresentation.

44 3. The named insured, any person who resides in the same household
45 as the named insured and WHO customarily operates a motor vehicle insured

1 under the policy or any other person who regularly and frequently operates
2 a motor vehicle insured under the policy:

3 (a) Has had the person's driver license suspended or revoked during
4 the policy period.

5 (b) Develops a permanent disability, either physically or mentally,
6 and ~~such individual~~ THE PERSON does not produce a certificate from a
7 physician or a registered nurse practitioner testifying to ~~such~~ THE
8 person's ability to operate a motor vehicle.

9 (c) Is or has been convicted during the thirty-six months
10 immediately preceding the effective date of the policy or during the
11 policy period of:

12 (i) Criminal negligence resulting in death, homicide or assault and
13 arising out of the operation of a motor vehicle.

14 (ii) Operating a motor vehicle while in an intoxicated condition or
15 while under the influence of drugs.

16 (iii) Leaving the scene of an accident.

17 (iv) Making false statements in an application for a driver
18 license.

19 (v) Reckless driving.

20 4. The insurer is placed in rehabilitation or receivership by the
21 insurance supervisory official in its state of domicile or by a court of
22 competent jurisdiction or the director has suspended the insurer's
23 certificate of authority based on its financially hazardous condition.

24 5. The named insured, any person who resides in the same household
25 as the named insured and WHO customarily operates a motor vehicle insured
26 under the policy or any other person who regularly and frequently operates
27 a motor vehicle insured under the policy uses a motor vehicle rated or
28 insured under the policy as a private passenger motor vehicle regularly
29 and frequently for commercial purposes.

30 6. ~~From and after February 29, 2016,~~ The named insured, any person
31 who resides in the same household as the named insured and who customarily
32 operates a motor vehicle insured under the policy or any other person who
33 regularly and frequently operates a motor vehicle insured under the policy
34 uses a motor vehicle rated or insured under the policy to provide
35 transportation network services unless, while the driver is logged in to
36 the transportation network company's digital network or software
37 application to be a driver or is providing transportation network
38 services, the named insured either:

39 (a) Has procured an endorsement to the private passenger policy
40 that expressly provides such coverage.

41 (b) Is covered by a motor vehicle liability insurance policy issued
42 by another insurer expressly providing such coverage.

43 7. The director determines that the continuation of the policy
44 would place the insurer in violation of the laws of this state or would
45 jeopardize the solvency of the insurer.

1 E. An insurer may nonrenew a motor vehicle insurance policy if the
2 insurer complies with ~~the requirements of~~ this article. An insurer shall
3 provide notice of a nonrenewal to the named insured as prescribed by
4 section 20-1632. A named insured who disputes the nonrenewal of the named
5 insured's policy may file an objection with the director pursuant to
6 section 20-1633.

7 F. The company shall not cancel the insurance when a person other
8 than the named insured has violated subsection D, paragraph 3 of this
9 section, if the named insured in writing agrees to exclude as insured the
10 person by name when operating a motor vehicle and further agrees to
11 exclude coverage to the named insured for any negligence that may be
12 imputed by law to the named insured arising out of the maintenance,
13 operation or use of a motor vehicle by the excluded person. The written
14 agreement that excludes coverage under a policy for a named individual is
15 effective for each renewal of the policy by the insurer and remains in
16 effect until the insurer agrees in writing to provide coverage for the
17 named individual who was previously excluded from coverage.

18 G. This article does not apply to any policy that has been in
19 effect less than sixty days at the time notice of cancellation is mailed
20 or delivered by the insurer unless the policy is a renewal policy, or to
21 policies:

22 1. Insuring any motor vehicle other than a private passenger motor
23 vehicle as defined in section 20-117.

24 2. Insuring the motor vehicle hazard of garages, motor vehicle
25 sales agencies, repair shops, service stations or public parking places.

26 3. Providing insurance only on an excess basis.

27 H. If a consumer purchases motor vehicle insurance coverage from an
28 insurance producer licensed in this state, the insurance producer that
29 owns the policy expiration shall remain the insurance producer of record
30 for that insured. ~~in the event~~ IF the insurer terminates the insurance
31 producer's contract, the insurance producer shall continue to provide
32 customary services to the insured. The insurer shall provide the
33 insurance producer with a minimum degree of authority necessary to provide
34 customary services to the insured and shall provide the same level of
35 compensation for these services that were in effect ~~prior to~~ BEFORE the
36 termination of the insurance producer contract.

37 I. Subsection H of this section ~~shall~~ DOES not apply if one or more
38 of the following conditions exist:

39 1. The insurance producer of record has had its license suspended
40 or revoked by the department.

41 2. The insurance producer of record is indebted to the insurer.

42 3. The insured has supplied the insurer with a written request that
43 its insurance producer of record be changed to another insurance producer
44 of the insurer.

1 4. The insurance producer of record has authorized transfer of this
2 account to another licensed insurance producer of the insurer.

3 5. The director has determined after a public hearing that
4 continuation of this relationship is not in the best interest of the
5 public.

6 6. The insurance producer of record is under an exclusive contract
7 or contract requiring the insurance producer to submit all eligible
8 business to an insurer or group of insurers under a common management.

9 J. Subsection H of this section ~~shall~~ DOES not apply to any
10 transaction in which the expiration of the policies is owned by the
11 insurer.

12 K. Notwithstanding any law to the contrary, if an insurer chooses
13 to renew a policy, the issuance at renewal of revised policy provisions to
14 modify an existing policy by adding coverages or policy provisions,
15 modifying coverages or policy provisions or eliminating coverages or
16 policy provisions is not a nonrenewal or cancellation of the policy if the
17 modification of a basic coverage does not eliminate the essential benefit
18 of that basic coverage. If the modification of the basic coverage
19 eliminates the essential benefit of the basic coverage, the director shall
20 order the insurer to remove the modification from the policy. This
21 subsection does not allow the insurer, without the written consent of the
22 insured, to eliminate the basic coverages of the policy or to reduce the
23 monetary limits of any of the basic coverages of the policy that were
24 selected and agreed on. If an insurer chooses to renew a policy, this
25 subsection does not limit a policyholder from continuing to renew
26 uninsured or underinsured motorist coverage pursuant to section 20-259.01.
27 For the purposes of this subsection, "basic coverage" means any of the
28 following:

- 29 1. Bodily injury coverage.
- 30 2. Property damage coverage.
- 31 3. Uninsured motorist coverage.
- 32 4. Underinsured motorist coverage.
- 33 5. Medical payments coverage.
- 34 6. Comprehensive coverage.
- 35 7. Collision coverage.

36 L. For the purposes of this section, fail to renew or nonrenewal
37 does not include the issuance and delivery of a new policy within the same
38 insurer or an insurer under the same ownership or management as the
39 original insurer as provided in this subsection. An insurer may transfer
40 any of its policies to an affiliated insurer. ~~No AN insurer shall~~ MAY NOT
41 transfer policyholders because of their location of residence, age, race,
42 color, religion, sex, national origin or ancestry. ~~Transfers A TRANSFER~~
43 by an insurer pursuant to this subsection ~~shall~~ DOES not ~~be construed to~~
44 ~~permit~~ ALLOW THE INSURER TO APPLY a new unrestricted sixty-day period for
45 cancellation or nonrenewal.

1 M. Except as provided in this subsection, an insurer shall not
2 refuse to renew a policy ~~until after August 31, 1998~~, based on an
3 insured's failure to maintain membership in a bona fide association, until
4 both the insurer and bona fide association have complied with this
5 subsection and shall not refuse to renew any coverage continuously in
6 effect before September 1, 1998, subject to all the following:

7 1. In addition to any other reason provided in this section, an
8 insurer may refuse to renew an insurance policy issued pursuant to this
9 article if all of the following conditions apply:

10 (a) The insurer clearly discloses to the applicant and the insured
11 in the application for insurance and insurance policy that both the
12 payment of dues and current membership in the bona fide association are
13 prerequisites to obtaining or renewing the insurance.

14 (b) Any money paid to the bona fide association as a membership
15 fee:

16 (i) Is not used by the insurer directly or indirectly to defray any
17 costs or expenses in connection with the sale or purchase of the
18 insurance.

19 (ii) Is set independently of any factor used by the insurer to make
20 any judgment or determination about the eligibility of any individual,
21 including the member, an employee of a member or a dependent of a member,
22 to purchase or renew the insurance.

23 (c) The bona fide association has filed a certification with the
24 director verifying the eligibility of the insurer to refuse to renew an
25 insurance policy based on membership in the bona fide association.

26 2. To qualify as a bona fide association pursuant to this
27 subsection, the association shall meet all of the requirements of this
28 paragraph. The association shall file a statement with the director at
29 least thirty days before the commencement of the offer or sale of
30 insurance as provided by this subsection verifying that the association
31 meets the requirements of this paragraph. The association shall update
32 the filing required by this paragraph at least thirty days before the
33 effective date of any material change in the information contained in the
34 statement, and shall file a separate notice with the director if the
35 insurance described in the statement is no longer available through the
36 association. The statement shall include the following information:

37 (a) That the association has been in active existence for at least
38 five consecutive years immediately before the filing of the statement.

39 (b) That the association has been formed and maintained in good
40 faith for purposes other than obtaining or providing insurance and does
41 not condition membership in the association on the purchase of insurance.

42 (c) That the association has articles of incorporation and bylaws
43 or other similar governing documents.

1 (d) That the association does not condition membership in the
2 association or set membership fees on the eligibility of any individual,
3 including the member, an employee of the member or a dependent of the
4 member, to purchase or renew the insurance, or on any factor that the
5 insurer could not lawfully consider when setting rates.

6 (e) That the association has a relationship with a specific insurer
7 or insurers and identifies the insurer or insurers.

8 3. Membership fees collected by the bona fide association are not
9 premiums of the insurer that issued the coverage unless the bona fide
10 association:

11 (a) Uses any portion of the membership fees directly or indirectly
12 to defray any costs or expenses in connection with the sale or purchase of
13 the insurance.

14 (b) Sets or adjusts membership fees for any member of the bona fide
15 association based on any factor used by the insurer that issues the
16 insurance to make any judgment or determination about the eligibility of
17 any individual, including the member, an employee of the member or a
18 dependent of the member, to purchase or renew the insurance.

19 4. If the membership fees constitute premiums pursuant to paragraph
20 3 of this subsection, an insurer shall not refuse to renew a policy as
21 otherwise ~~permitted~~ ALLOWED by this subsection.

22 N. An insurer or insurance producer shall not inquire on an
23 application for a motor vehicle insurance policy whether the applicant,
24 any person who resides in the same household as the applicant and WHO
25 customarily operates a motor vehicle to be insured under the policy, or
26 any other person who regularly and frequently operates a motor vehicle to
27 be insured under the policy has been nonrenewed by an insurer.

28 O. An insurer may issue an endorsement to a private passenger
29 policy that expressly provides coverage for the provision of
30 transportation network services, but that endorsement may not be treated
31 as basic coverage as defined in subsection K of this section and any
32 termination of the endorsement may not be treated as a modification of
33 basic coverage. An insurer may terminate the endorsement allowed by this
34 subsection by giving advance notice of the termination. Any notice by the
35 insurer to the policyholder to terminate the endorsement allowed by this
36 subsection shall be ~~mailed~~ SENT to the named insured ~~by United States mail~~
37 at least forty-five days before the effective date of the termination.
38 The notice shall include an explanation to the named insured that the
39 further provision of transportation network services following the
40 effective date of the termination might subject the insured to
41 cancellation or nonrenewal of the insured's private passenger motor
42 vehicle policy.

1 P. This section and section 28-4009 do not create an obligation of
2 an insurer to offer, provide or issue a policy or an endorsement that
3 includes coverage for any liability incurred while a transportation
4 network company driver is logged in to the transportation network
5 company's digital network or software application to be a driver or is
6 providing transportation network services.

7 Q. For the purposes of this section, "transportation network
8 company", "transportation network company driver" and "transportation
9 network services" have the same meanings prescribed in section 28-9551.

10 Sec. 12. Section 20-1632, Arizona Revised Statutes, is amended to
11 read:

12 20-1632. Cancellation, nonrenewal and reduction of limits for
13 reasons other than nonpayment of premium; notices
14 to insured; refund of unearned premium

15 A. A notice by the insurer to the policyholder of cancellation or
16 reduction in the limits of liability or coverage for reasons other than
17 nonpayment of premium shall be ~~mailed~~ SENT to the named insured ~~with the~~
18 ~~insurer obtaining proof of mailing by United States certified mail, United~~
19 ~~States post office certificate of mailing or first class mail using~~
20 ~~intelligent mail barcode or another similar tracking method used or~~
21 ~~approved by the United States postal service~~ at least ten days before the
22 effective date of the cancellation or reduction in limits of liability or
23 coverage. Notice of nonrenewal for reasons other than nonpayment of
24 premium shall be ~~mailed~~ SENT at least forty-five days before the effective
25 date of the nonrenewal. A notice under this ~~section~~ SUBSECTION shall
26 include or be accompanied by all of the following:

27 1. A statement in writing of the specific facts that constitute the
28 reasons, consistent with this article, for such action by the insurer and
29 a notice indicating the named insured's right to complain to the director
30 of the insurer's action within ten days after receipt of the notice by the
31 insured.

32 2. Notice of the insured's possible eligibility for insurance
33 through the automobile assigned risk plan, and the notice shall state that
34 all information included in the notice is given pursuant to this article.

35 3. Except as provided in paragraph 4 of this subsection, a refund
36 of unearned premium. For the purposes of this paragraph, the insurer
37 shall either ~~mail~~ SEND the notice and refund of unearned premium together
38 at least ten days before the effective date or ~~mail~~ SEND the notice before
39 the refund of unearned premium if both the notice and the refund of
40 unearned premium are ~~mailed~~ SENT separately to the insured at least ten
41 days before the effective date. As an alternative to ~~mailing~~ SENDING THE
42 REFUND BY MAIL, an insurer may ~~choose to~~ refund the unearned premium by
43 any electronic means previously established with the ~~customer~~ INSURED to
44 make and receive premium payments for the policy.

1 Sec. 14. Section 20-1653, Arizona Revised Statutes, is amended to
2 read:

3 20-1653. Sending notice of cancellation or nonrenewal to
4 insured; statement of grounds and facts on which
5 cancellation or nonrenewal is based

6 All notices of cancellation or nonrenewal shall be in writing, shall
7 be ~~mailed~~ SENT to the named insured ~~at the address shown in the policy or~~
8 ~~to the last known address of the insured~~ and shall state, with respect to
9 cancellation of policies in effect after the time limits specified in
10 section 20-1652 and, in the case of nonrenewal of policies as specified in
11 section 20-1654:

12 1. In the case of cancellation ~~which~~ THE specific facts THAT
13 constitute the grounds set forth in section 20-1652 relied ~~upon~~ ON.

14 2. In the case of nonrenewal the specific facts ~~which~~ THAT
15 constitute the reason the policy is not being renewed, which may
16 include, ~~but are not limited to,~~ the grounds set forth in section 20-1652.

17 Sec. 15. Section 20-1654, Arizona Revised Statutes, is amended to
18 read:

19 20-1654. Sending notice of intention not to renew to insured;
20 time; term of policy

21 A. Unless the insurer, at least thirty days ~~in advance of~~ BEFORE
22 the end of the policy period, ~~mails or delivers~~ SENDS to the named insured
23 ~~at the address shown in the policy,~~ notice of its intention not to renew
24 the policy or to condition its renewal ~~upon~~ ON reduction of limits or
25 elimination of coverages, the insurer shall not fail to renew the policy
26 ~~upon~~ ON payment of the premium due on the effective date of the renewal,
27 in accordance with the then existing rating manual of the insurer. For
28 the purposes of this section, any policy written for a term of less than
29 one year may be renewed for a term of one year if the notice is not given
30 as required by this subsection. For the purposes of this subsection, a
31 policy with no fixed expiration date shall be deemed written for
32 successive policy periods of one year.

33 B. This section ~~shall~~ DOES not apply if the insured has accepted
34 replacement coverage or has agreed to nonrenewal.

35 Sec. 16. Section 20-1656, Arizona Revised Statutes, is amended to
36 read:

37 20-1656. Proof of sending as proof of notice

38 A. Proof of ~~mailing of~~ SENDING a notice of cancellation and the
39 reasons for cancellation or of intention not to renew to the named insured
40 BY MAIL at the address shown in the policy ~~shall be~~ IS sufficient proof of
41 the notice required by this article.

42 B. ANY METHOD OF PROOF RETAINED BY THE INSURER FOR SENDING A NOTICE
43 OF CANCELLATION BY ANY METHOD OTHER THAN BY MAIL IS SUFFICIENT PROOF OF
44 THE NOTICE REQUIRED BY THIS ARTICLE.

1 Sec. 17. Section 20-1674, Arizona Revised Statutes, is amended to
2 read:

3 20-1674. Notice of cancellation; refund of unearned premium

4 A. ~~No~~ A cancellation under section 20-1673 is NOT effective unless
5 the insurer ~~mails or electronically delivers, consistent with the~~
6 ~~requirements of title 44, chapter 26,~~ SENDS a copy of the notice of
7 cancellation to the insured's agent and ~~written notice of the cancellation~~
8 ~~is mailed with the insurer obtaining proof of mailing by United States~~
9 ~~certified mail or first class mail using intelligent mail barcode or~~
10 ~~another similar tracking method used or approved by the United States~~
11 ~~postal service to the named insured at the address shown in the policy or~~
12 ~~to the last known address of the insured~~ at least forty-five days before
13 the effective date of the cancellation, except that, if cancellation is
14 for nonpayment of premium, at least ten days' notice of cancellation must
15 be given. The notice must state the specific facts that constitute the
16 grounds set forth in section 20-1673 that are relied on. IF THE INSURER
17 SENDS THE NOTICE BY MAIL, THE INSURER SHALL OBTAIN PROOF OF MAILING BY
18 UNITED STATES CERTIFIED MAIL OR FIRST CLASS MAIL USING INTELLIGENT MAIL
19 BARCODE OR ANOTHER SIMILAR TRACKING METHOD USED OR APPROVED BY THE UNITED
20 STATES POSTAL SERVICE.

21 B. The notice of cancellation and any refund of unearned premium
22 may be ~~mailed~~ SENT separately, but both must be ~~mailed~~ SENT within the
23 time frames established in subsection A, of this section. If a premium
24 has been financed, a refund of unearned premium shall be returned as
25 provided in section 6-1416.

26 Sec. 18. Section 20-1676, Arizona Revised Statutes, is amended to
27 read:

28 20-1676. Notice of nonrenewal

29 A. This article does not apply to the nonrenewal of insurance
30 policies except as provided in subsection B of this section.

31 B. ~~No~~ A nonrenewal of any policy of insurance to which this article
32 applies is NOT effective unless the insurer ~~mails or electronically~~
33 ~~delivers, consistent with the requirements of title 44, chapter 26,~~ SENDS
34 a copy of the notice of nonrenewal to the insured's agent ~~and mails with~~
35 ~~the insurer obtaining proof of mail by United States certified mail or~~
36 ~~first class mail using intelligent mail barcode or another similar~~
37 ~~tracking method used or approved by the United States postal service~~
38 ~~written notice to the named insured, at the address shown in the policy or~~
39 ~~to the last known address of the insured,~~ at least forty-five days before
40 the end of the policy period, of its intention not to renew the policy.
41 The transfer of a policyholder between companies within the same insurance
42 group or changes in deductibles, premium, amount of insurance or coverage
43 are not refusals to renew.

44 C. Notice of nonrenewal is not required if either of the following
45 occurs:

1 1. The insurer or a company within the same insurance group has
2 offered to issue a renewal policy.

3 2. The named insured has obtained replacement coverage or has
4 agreed in writing to obtain replacement coverage.

5 D. If an insurer provides the notice described in subsection B of
6 this section and the insurer subsequently extends the policy for ninety
7 days at the request of the policyholder, an additional notice of
8 nonrenewal is not required with respect to the extension.

9 E. If the notice of nonrenewal is ~~mailed~~ SENT less than forty-five
10 days before expiration, the coverage ~~shall remain~~ REMAINS in effect until
11 forty-five days after the notice is ~~mailed~~ SENT. Earned premium for any
12 period of coverage that extends beyond the expiration date shall be
13 considered pro rata based on the previous year's rate.

14 Sec. 19. Section 20-1677, Arizona Revised Statutes, is amended to
15 read:

16 20-1677. Notice of premium or coverage changes

17 A. An insurer shall ~~mail or deliver~~ SEND to the named insured ~~at~~
18 ~~the mailing address shown on the policy~~ written notice of A premium
19 increase, change in deductible or reduction in limits or substantial
20 reduction in coverage at least thirty days before the expiration date of
21 the policy. If the insurer fails to provide the thirty days' notice, the
22 coverage provided to the named insured remains in effect until notice is
23 given or until the effective date of replacement coverage obtained by the
24 named insured, whichever occurs first.

25 B. Notice is considered given thirty days ~~following~~ AFTER the date
26 ~~of mailing or delivery of~~ the notice IS SENT. If the insured elects not
27 to renew, any earned premium for the period of extension of the terminated
28 policy shall be calculated pro rata at the lower of the current or
29 previous year's rate. If the insured accepts the renewal, the premium
30 increase, if any, and other changes are effective the day following the
31 prior policy's expiration or anniversary date.

32 C. For the purposes of this section, notice ~~shall be~~ IS considered
33 given if an insurer delivers new policy terms and conditions thirty days
34 before the expiration date of the policy.

35 Sec. 20. Section 20-1678, Arizona Revised Statutes, is amended to
36 read:

37 20-1678. Proof of notice

38 A. Proof of ~~mailing of the~~ SENDING A notice ~~or~~ OF cancellation, or
39 of nonrenewal or of premium or coverage changes, BY MAIL to the named
40 insured at the address shown in the policy is sufficient proof of notice.

41 B. ANY METHOD OF PROOF RETAINED BY THE INSURER FOR SENDING A NOTICE
42 OF CANCELLATION, OR OF NONRENEWAL OR OF PREMIUM OR COVERAGE CHANGES, BY
43 ANY METHOD OTHER THAN BY MAIL IS SUFFICIENT PROOF OF NOTICE.

1 ~~delivers~~ SENDS written notice of the cancellation, nonrenewal or
2 conditional renewal to the group policyholder ~~at the mailing address shown~~
3 ~~in the policy~~ and to affected certificate holders ~~at each certificate~~
4 ~~holder's last known mailing address~~. If authorized by the insurer, the
5 group policyholder may ~~mail or deliver~~ SEND the notice to the certificate
6 holder on behalf of the insurer.

7 C. A group policyholder may cancel the group policy for any reason
8 on thirty days' written notice to the insurer and each affected group
9 member. A group policyholder is not required to give notice to a group
10 member if substantially similar coverage has been obtained from another
11 insurer without a lapse of coverage.

12 D. If a group member sustains a loss pursuant to a stolen identity
13 event that occurs before the effective date of the cancellation,
14 nonrenewal or conditional renewal of a group policy or the cancellation,
15 nonrenewal, conditional renewal or termination of a certificate, whether
16 initiated by the insurer, group policyholder or group member, the loss
17 remains covered as provided under the policy notwithstanding the
18 cancellation, nonrenewal, conditional renewal or termination.

19 Sec. 22. Section 20-2110, Arizona Revised Statutes, is amended to
20 read:

21 20-2110. Reasons for adverse underwriting decisions

22 A. In the event of an adverse underwriting decision the insurance
23 institution or insurance producer responsible for the decision shall
24 either provide the applicant, policyholder or individual proposed for
25 coverage with the specific reason for the adverse underwriting decision in
26 writing or advise the person, in writing, that ~~upon~~ ON written request the
27 person may receive the specific reason in writing and provide the
28 applicant, policyholder or individual proposed for coverage with a summary
29 of the rights established under subsection B of this section and sections
30 20-2108 and 20-2109.

31 B. ~~upon~~ ON receipt of a written request within ninety business days
32 ~~from~~ AFTER the date ~~of~~ the ~~mailing of~~ notice or other communication of an
33 adverse underwriting decision IS SENT to an applicant, policyholder or
34 individual proposed for coverage, the insurance institution or insurance
35 producer shall ~~furnish~~ SEND to the person within twenty-one business days
36 ~~from~~ AFTER the date of receipt of the written request:

37 1. The specific reason for the adverse underwriting decision, in
38 writing, if the information was not initially furnished in writing
39 pursuant to subsection A of this section.

40 2. The specific items of personal and privileged information that
41 support those reasons except that:

42 (a) The insurance institution or insurance producer is not required
43 to furnish specific items of privileged information if it has a reasonable
44 suspicion, based ~~upon~~ ON specific information available for review by the
45 director, that the applicant, policyholder or individual proposed for

1 coverage has engaged in criminal activity, fraud, material
2 misrepresentation or material nondisclosure.

3 (b) Specific items of medical record information supplied by a
4 medical care institution or medical professional shall be disclosed either
5 directly to the individual about whom the information relates or to a
6 medical professional designated by the individual and licensed to provide
7 medical care with respect to the condition to which the information
8 relates, at the option of the insurance institution or insurance producer.

9 3. The names and addresses of the institutional sources that
10 supplied the specific items of information pursuant to paragraph 2 of this
11 subsection, except that the identity of any medical professional or
12 medical care institution shall be disclosed either directly to the
13 individual or to the designated medical professional, whichever the
14 insurance institution or insurance producer prefers.

15 C. The obligations imposed by this section ~~upon~~ ON an insurance
16 institution or insurance producer may be satisfied by another insurance
17 institution or insurance producer authorized to act on its behalf.

18 D. If an adverse underwriting decision results solely from an oral
19 request or inquiry, the explanation of the specific reasons and summary of
20 rights required by subsection A of this section may be given orally.

21 E. In providing the specific reason for an adverse underwriting
22 decision based on credit related information contained or not contained in
23 an individual's consumer report, the insurance institution or agent shall
24 provide at least the following information:

25 1. That the decision was based in part on a consumer report or the
26 absence of credit history.

27 2. The source of the consumer report and how the individual may
28 obtain a copy of the consumer report.

29 3. A description of up to four factors that were the primary cause
30 for the adverse action that resulted from the insurance score.

31 F. An insurer shall not use the following types of credit history
32 to calculate an insurance score to determine property or casualty premiums
33 for insurance transactions that are subject to this article and shall not
34 knowingly use an insurance score developed by a third party if the score
35 is calculated using any of the following types of credit history:

36 1. The absence of credit history or the inability to determine the
37 consumer's credit history unless the insurer's action is actuarially
38 justified or the insurer treats the consumer as if the consumer had
39 neutral credit information, as defined by the insurer.

40 2. Credit history or an insurance score based on collection
41 accounts identified with a medical industry code.

42 3. A bankruptcy or a lien satisfaction that is more than seven
43 years old.

44 4. The consumer's use of a particular type of credit card, charge
45 card or debit card unless actuarially justified.

1 5. The consumer's total available line of credit, except that an
2 insurer may consider the total amount of outstanding debt in relation to
3 the total available line of credit.

4 6. An insurance score that is calculated using the income, gender,
5 address, zip code, ethnic group, religion, marital status or nationality
6 of the consumer as a factor. This ~~section~~ PARAGRAPH does not prohibit an
7 insurer from using zip code, address, gender and marital status
8 information for underwriting purposes.

9 Sec. 23. Section 20-2209, Arizona Revised Statutes, is amended to
10 read:

11 20-2209. Claims-made policy; cancellation

12 A policy issued pursuant to this chapter may provide that the
13 association may cancel any of its policies for the reasons specified in
14 section 20-1673 or in the event of nonpayment of any premium assessment or
15 other charge by ~~mailing or delivering~~ SENDING to the insured ~~at the~~
16 ~~address shown in the policy~~ written notice at least ten days before the
17 effective date of the cancellation.

18 Sec. 24. Section 20-2533, Arizona Revised Statutes, is amended to
19 read:

20 20-2533. Denial; levels of review; disclosure; review process

21 A. Any member who is denied a covered service or whose claim for a
22 service is denied may pursue the applicable review process prescribed in
23 this article. Except as provided in sections 20-2534 and 20-2535, health
24 care insurers shall provide at least the following levels of review, as
25 applicable:

26 1. An expedited medical review and expedited appeal pursuant to
27 section 20-2534.

28 2. An informal reconsideration pursuant to section 20-2535.

29 3. A formal appeal process pursuant to section 20-2536.

30 4. An external independent review pursuant to section 20-2537.

31 B. A health care insurer may offer additional levels of review
32 other than the levels prescribed in subsection A of this section as long
33 as the additional levels of review do not increase the time period
34 limitations prescribed by this article.

35 C. At the time coverage is initiated, each health care insurer that
36 operates in this state and whose utilization review system includes the
37 power to affect the direct or indirect denial of requested medical or
38 health care services or claims for medical or health care services shall
39 include a separate information packet that is approved by the director
40 with the member's policy, evidence of coverage or similar document. At
41 the time coverage is renewed, each health care insurer shall include a
42 separate statement with the member's policy, evidence of coverage or
43 similar document that informs the member that the member can obtain a
44 replacement packet that explains the appeal process by contacting a
45 specific department and telephone number. A health care insurer shall

1 also provide a copy of the information packet to the member or the
2 member's treating provider on request and ~~to the member within five~~
3 ~~business days after the date the appeal is initiated pursuant to section~~
4 ~~20-2534, 20-2535 or 20-2536~~ PROVIDE ACCESS TO A COPY OF THE INFORMATION
5 PACKET ON ITS WEBSITE. The information packet provided by the health care
6 insurer shall include all of the following information:

7 1. A detailed description and explanation of each level of review
8 prescribed in subsection A of this section and notice of the member's
9 right to proceed to the next level of review if the prior review is
10 unsuccessful.

11 2. An explanation of the procedures that the member must follow,
12 including the applicable time periods, for each level of review prescribed
13 in subsection A of this section and an explanation of how the member may
14 obtain the member's medical records pursuant to title 12, chapter 13,
15 article 7.1.

16 3. The specific title and department of the person and the address,
17 telephone number and ~~telefacsimile~~ FAX number OR EMAIL ADDRESS of ~~that~~ THE
18 person whom the member must notify at each level of review prescribed in
19 subsection A of this section in order to pursue that level of review.

20 4. The specific title and department of the person and the address,
21 telephone number and ~~telefacsimile~~ FAX number OR EMAIL ADDRESS of the
22 person who will be responsible for processing that review.

23 5. A notice that if the member decides to pursue an appeal the
24 member must provide the person who will be responsible for processing the
25 appeal with any material justification or documentation for the appeal at
26 the time that the member files the written appeal.

27 6. A description of the utilization review agent's and health care
28 insurer's roles at each level of review prescribed by subsection A of this
29 section and an outline of the director's role during the external
30 independent review process, if not already described in response to
31 paragraph 1 of this subsection.

32 7. A notice that if the member participates in the process of
33 review pursuant to this article the member waives any privilege of
34 confidentiality of the member's medical records regarding any person who
35 examined or will examine the member's medical records in connection with
36 that review process for the medical condition under review.

37 8. A statement that the member is not responsible for the costs of
38 any external independent review.

39 9. Standardized forms that are prescribed by the department and
40 that a member may use to file and pursue an appeal.

41 10. The name and telephone number for the department of insurance
42 AND FINANCIAL INSTITUTIONS consumer assistance office with a statement
43 that the department of insurance AND FINANCIAL INSTITUTIONS consumer
44 assistance office can assist consumers with questions about the health
45 care appeals process.

1 D. At the time of issuing a denial, the health care insurer shall
2 notify the member of the right to appeal under this article. A health
3 care insurer that issues an explanation of benefits document shall satisfy
4 this obligation by prominently displaying in the document a statement
5 about the right to appeal. A health care insurer that does not issue an
6 explanation of benefits document shall satisfy this obligation through
7 some other reasonable means to assure that the member is apprised of the
8 right to appeal at the time of a denial. A reasonable means that includes
9 giving the member's treating provider a form statement about the right to
10 appeal shall require the treating provider to notify the member of the
11 member's right to appeal.

12 E. Any written notice, acknowledgment, request, decision or other
13 written document ~~required to be mailed pursuant to this article~~ THAT IS
14 SENT BY MAIL is deemed received by the person to whom the document is
15 properly addressed on the fifth business day after ~~the request is mailed.~~
16 ~~For the purposes of this subsection "properly addressed" means the last~~
17 ~~known address~~ MAILING.

18 F. The director shall require any member who files a complaint with
19 the department relating to an adverse decision to pursue the review
20 process prescribed in this article. This subsection does not limit the
21 director's authority pursuant to chapter 1, article 2 of this title.

22 G. If the member's complaint is an issue of medical necessity under
23 the coverage document and not whether the claim or service is covered, the
24 informal reconsideration shall be performed as prescribed by section
25 20-2535 by a licensed health care professional. If the member's complaint
26 is an issue of medical necessity under the coverage document and not
27 whether the claim or service is covered, the expedited review or formal
28 appeal shall be decided by a physician, provider or other health care
29 professional as prescribed by section 20-2534 or 20-2536. Any external
30 independent review shall be decided by a physician, provider or other
31 health care professional as prescribed by section 20-2537.

32 H. Any person given access to a member's medical records or other
33 medical information in connection with proceedings pursuant to this
34 article shall maintain the confidentiality of the records or information
35 in accordance with title 12, chapter 13, article 7.1.

36 Sec. 25. Section 20-2534, Arizona Revised Statutes, is amended to
37 read:

38 20-2534. Expedited medical review; expedited appeal

39 A. Any member who is denied a request for a covered service may
40 pursue an expedited medical review of that denial if the member's treating
41 provider certifies in writing and provides supporting documentation to the
42 utilization review agent that the time period for the informal
43 reconsideration process and formal appeal process prescribed in sections
44 20-2535 and 20-2536 is likely to cause a significant negative change in
45 the member's medical condition at issue that is subject to the appeal.

1 The treating provider's certification is not challengeable by the health
2 care insurer. A health care insurer whose utilization review activities
3 consist only of claims review for services already provided is not
4 required to provide its members an expedited medical review or expedited
5 appeal pursuant to this section. A health care insurer who conducts
6 utilization review of claims in connection with services already provided
7 is not required to provide its members an expedited medical review or
8 expedited appeal of a claim related to a service already provided.

9 B. On receipt of the certification and supporting documentation,
10 the utilization review agent has one business day to make a decision and
11 ~~mail~~ SEND to the member and the member's treating provider a notice of
12 that decision, including the criteria used and the clinical reasons for
13 that decision and any references to supporting documentation. If the
14 member's complaint is an issue of medical necessity under the coverage
15 document and not whether the service is covered, before making a decision,
16 the agent shall consult with a physician or other health care professional
17 who is licensed pursuant to title 32, chapter 7, 8, 11, 13, 14, 17, 19 or
18 29 or an ~~out-of-state~~ OUT-OF-STATE provider, physician or other health
19 care professional who is licensed in another state and who is not licensed
20 in this state and who typically manages the medical condition under
21 review.

22 C. If the utilization review agent affirms the denial of the
23 requested service, the agent shall telephonically provide and ~~mail~~ SEND to
24 the member and the member's treating provider a notice of the adverse
25 decision and of the member's option to immediately proceed to an expedited
26 appeal pursuant to subsection E of this section.

27 D. At any time during the expedited appeal process, the utilization
28 review agent may request an expedited external independent review ~~process~~
29 pursuant to section 20-2537. If the utilization review agent initiates
30 ~~the~~ AN expedited external independent review ~~process~~, the utilization
31 review agent does not have to comply with subsection E of this section.

32 E. If the member chooses to proceed with an expedited appeal, the
33 member's treating provider shall immediately submit a written appeal of
34 the denial of the service to the utilization review agent and provide the
35 utilization review agent with any additional material justification or
36 documentation to support the member's request for the service. Within
37 three business days after receiving the request for an expedited appeal,
38 the utilization review agent shall provide notice of the expedited appeal
39 decision as prescribed in this subsection. If the member's complaint is
40 an issue of medical necessity under the coverage document and not whether
41 the service is covered, any provider, physician or other health care
42 professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13,
43 14, 16, 17, 19, 19.1 or 29 or an ~~out-of-state~~ OUT-OF-STATE provider,
44 physician or other health care professional who is licensed in another
45 state and who is not licensed in this state, who is employed or under

1 contract with the utilization review agent and who is qualified in a
2 similar scope of practice as a provider, physician or other health care
3 professional who is licensed pursuant to title 32, chapter 7, 8, 11, 13,
4 14, 16, 17, 19, 19.1 or 29 or an ~~out-of-state~~ OUT-OF-STATE provider,
5 physician or other health care professional who is licensed in another
6 state and who is not licensed in this state and who typically manages the
7 medical condition under appeal shall review the expedited appeal and
8 render a decision based on the utilization review plan adopted by the
9 utilization review agent. Pursuant to the requirements of this
10 subsection, the utilization review agent shall select the provider,
11 physician or other health care professional who shall review the appeal
12 and render the decision. If the utilization review agent, provider,
13 physician or other health care professional denies the expedited appeal,
14 the utilization review agent shall telephonically provide and ~~mail~~ SEND to
15 the member and the member's treating provider a notice of the denial and
16 of the member's option to immediately proceed to the external independent
17 review prescribed in section 20-2537.

18 F. If the utilization review agent, provider, physician or other
19 health care professional concludes that the covered service should be
20 provided, the health care insurer is bound by the utilization review
21 agent's decision.

22 Sec. 26. Section 20-2535, Arizona Revised Statutes, is amended to
23 read:

24 20-2535. Informal reconsideration

25 A. Any member who is denied a service and who does not qualify for
26 an expedited medical review pursuant to section 20-2534 may request,
27 either orally or in writing, an informal reconsideration of that denial by
28 notifying the person described in section 20-2533, subsection C,
29 paragraph 3. After the denial, the member has up to two years to request
30 an informal reconsideration. A health care insurer whose utilization
31 review consists only of claims review for services already provided is not
32 required to provide its members an informal reconsideration pursuant to
33 this section. A health care insurer who conducts utilization review of
34 claims in connection with services already provided is not required to
35 provide its members an informal reconsideration of a claim related to a
36 service already provided.

37 B. The utilization review agent shall ~~mail~~ SEND a written
38 acknowledgment to the member and the member's treating provider within
39 five business days after the utilization review agent receives the request
40 for informal reconsideration.

41 C. The utilization review agent may request any pertinent medical
42 records pursuant to title 12, chapter 13, article 7.1 that are necessary
43 for the informal reconsideration.

1 D. The utilization review agent has up to thirty days after receipt
2 of the request for reconsideration to ~~mail~~ SEND to the member and the
3 member's treating provider a notice of the utilization review agent's
4 decision and the criteria used and the clinical reasons for that decision.

5 E. At any time during the informal reconsideration process, the
6 utilization review agent may submit a request to the director to initiate
7 an external independent review process pursuant to section 20-2537. At
8 the same time that the utilization review agent submits the request to the
9 director, the utilization review agent shall also render a written
10 decision and shall send the written decision, including the criteria used
11 and the clinical reasons for that decision and any references to
12 supporting documentation, to the member, the member's treating provider
13 and the director.

14 F. If the utilization review agent does not submit a request to the
15 director pursuant to subsection E of this section and at the conclusion of
16 the informal reconsideration process the utilization review agent denies
17 the covered service or the claim for the covered service, the utilization
18 review agent shall provide the member and the treating provider with a
19 written statement of the agent's decision and the criteria used and the
20 clinical reasons for that decision, including any references to any
21 supporting documentation and a notice of the option to proceed after the
22 formal appeal process to an external independent review.

23 G. If the utilization review agent concludes that the covered
24 service should be provided or the claim for a covered service should be
25 paid, the health care insurer is bound by the utilization review agent's
26 decision.

27 Sec. 27. Section 20-2536, Arizona Revised Statutes, is amended to
28 read:

29 20-2536. Formal appeal

30 A. After any applicable informal reconsideration pursuant to
31 section 20-2535, if the utilization review agent denies the member's
32 request for a covered service, the member may appeal that adverse
33 decision. The member shall ~~mail~~ SEND a written appeal to the utilization
34 review agent within sixty days after receipt of the adverse decision. In
35 the event of a denial of a claim for a service that has already been
36 provided, the member may appeal that denial by filing a written appeal
37 with the utilization review agent within two years after receipt of the
38 notice of the denial.

39 B. The utilization review agent shall ~~mail~~ SEND a written
40 acknowledgment to the member and the member's treating provider within
41 five business days after the agent receives the formal appeal.

42 C. The member or the member's treating provider shall submit to the
43 utilization review agent with the written formal appeal any material
44 justification or documentation to support the member's request for the
45 service or claim for a service.

1 D. If the member's complaint is an issue of medical necessity under
2 the coverage document and not whether the service is covered, a provider,
3 physician or other health care professional who is licensed pursuant to
4 title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an ~~out of~~
5 ~~state~~ OUT-OF-STATE provider physician or other health care professional
6 who is licensed in another state and who is not licensed in this state,
7 who is employed or under contract with the utilization review agent and
8 who is qualified in a similar scope of practice as a provider, physician
9 or other health care professional licensed pursuant to title 32, chapter
10 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an ~~out of state~~ OUT-OF-STATE
11 provider, physician or other health care professional who is licensed in
12 another state and who is not licensed in this state and who typically
13 manages the medical condition under appeal shall review the appeal and
14 render a decision based on the utilization review plan adopted by the
15 utilization review agent. Pursuant to the requirements of this
16 subsection, the utilization review agent shall select the provider,
17 physician or other health care professional who shall review the appeal
18 and render the decision.

19 E. Except as provided in subsection F of this section, the
20 utilization review agent has:

21 1. With respect to adverse decisions relating to services that have
22 not been provided, up to thirty days after receipt of the written appeal
23 to notify the member in writing of the utilization review agent's decision
24 and the criteria used and the clinical reasons for that decision.

25 2. With respect to denials relating to claims that have already
26 been provided, up to sixty days after receipt of the written appeal to
27 notify the member in writing of the utilization review agent's decision
28 and the criteria used and the clinical reasons for that decision.

29 F. At any time during the formal appeal process, the utilization
30 review agent may request an external independent review process pursuant
31 to section 20-2537. If the utilization review agent initiates the
32 external independent review process, the utilization review agent does not
33 have to comply with subsection E of this section.

34 G. If at the conclusion of the formal appeal process the
35 utilization review agent denies the appeal and the utilization review
36 agent does not initiate the external independent review process, the
37 utilization review agent shall provide the member with notice of the
38 option to proceed to an external independent review pursuant to section
39 20-2537.

40 H. If the utilization review agent concludes that the covered
41 service should be provided or the claim for a covered service should be
42 paid, the health care insurer is bound by the utilization review agent's
43 decision.

1 E. Except as provided in subsection K of this section, for cases
2 involving an issue of medical necessity under the coverage document,
3 within twenty-one days after the date of receiving a case for independent
4 review from the director, the independent review organization shall
5 evaluate and analyze the case and, based on all information required under
6 subsection C, paragraph 2 of this section, render a decision that is
7 consistent with the utilization review plan on whether or not the service
8 or claim for the service is medically necessary and send the decision to
9 the director. Within five business days after receiving a notice of
10 decision from the independent review organization, the director shall ~~mail~~
11 SEND a notice of the decision to the utilization review agent, the health
12 care insurer, the member and the member's treating provider. The decision
13 by the independent review organization is a final administrative decision
14 pursuant to title 41, chapter 6, article 10 and is subject to judicial
15 review pursuant to title 12, chapter 7, article 6. The health care
16 insurer shall provide any service or pay any claim determined to be
17 covered and medically necessary by the independent review organization for
18 the case under review regardless of whether judicial review is sought.

19 F. Except as provided in subsection K of this section, for cases
20 involving an issue of coverage, within fifteen business days after receipt
21 of all of the information prescribed in subsection C, paragraph 2 of this
22 section from the utilization review agent, the director shall determine if
23 the service or claim is or is not covered and if the adverse decision made
24 pursuant to section 20-2536 conforms to the utilization review agent's
25 utilization review plan and this article and shall ~~mail~~ SEND a notice of
26 determination to the utilization review agent, the health care insurer,
27 the member and the member's treating provider.

28 G. If the director finds that the case involves a medical issue or
29 is unable to determine issues of coverage, the director shall submit the
30 member's case to the external independent review organization in
31 accordance with subsections E and K of this section.

32 H. After a decision is made pursuant to subsection E, F, G or K of
33 this section, the reconsideration, appeal and administrative processes are
34 completed and the department's role is ended, except:

- 35 1. To transmit, when necessary, a record of the proceedings to
36 superior court or to the office of administrative hearings.
37 2. To issue a final administrative decision pursuant to section
38 41-1092.08.

39 I. Except as provided in subsection K of this section, on written
40 request by the independent review organization, the member or the
41 utilization review agent, the director may extend the twenty-one day time
42 period prescribed in subsection E of this section for up to an additional
43 thirty days if the requesting party demonstrates good cause for an
44 extension.

1 J. A decision made by the director or an independent review
2 organization pursuant to this section is admissible in proceedings
3 involving a health care insurer or utilization review agent.

4 K. If the utilization review agent denies the member's request for
5 a covered service or claim for a covered service at the expedited medical
6 review level presented and resolved pursuant to section 20-2534,
7 subsections A and E, the member may initiate an expedited external
8 independent review in accordance with the following:

9 1. Within five business days after the member receives written
10 notice by the utilization review agent of the adverse decision made
11 pursuant to section 20-2534, if the member decides to initiate an external
12 independent review, the member shall ~~mail~~ SEND to the utilization review
13 agent a written request for an expedited external independent review,
14 including any material justification or documentation to support the
15 member's request for the covered service or claim for a covered service.

16 2. Within one business day after the utilization review agent
17 receives a request for an expedited external independent review from the
18 member pursuant to this subsection or if the utilization review agent
19 initiates an expedited external independent review pursuant to section
20 20-2534, subsection D, the utilization review agent shall:

21 (a) ~~Mail~~ SEND a written acknowledgment to the director, the member,
22 the member's treating provider and the health care insurer.

23 (b) Forward to the director the request for an expedited
24 independent external review, the terms of agreement in the member's
25 policy, evidence of coverage or a similar document and all medical records
26 and supporting documentation used to render the decision pertaining to the
27 member's case, a summary description of the applicable issues including a
28 statement of the utilization review agent's decision, the criteria used
29 and the clinical reasons for that decision, the relevant portions of the
30 utilization review agent's utilization review plan and the name and
31 credentials of the licensed health care provider who reviewed the case as
32 required by section 20-2534, subsection B.

33 3. Within two business days after the director receives all of the
34 information prescribed in this subsection and if the case involves an
35 issue of medical necessity, the director shall choose an independent
36 review organization procured pursuant to section 20-2538 and forward to
37 the organization all of the information required by this subsection.

38 4. For cases involving an issue of medical necessity, within
39 seventy-two hours from the date of receiving a case for expedited external
40 independent review from the director, the independent review organization
41 shall evaluate and analyze the case and, based on all information required
42 under subsection C, paragraph 2 of this section, render a decision that is
43 consistent with the utilization review plan on whether or not the service
44 or claim for the service is medically necessary and send the decision to
45 the director. Within one business day after receiving a notice of

1 decision from the independent review organization, the director shall ~~mail~~
2 SEND a notice of the decision to the utilization review agent, the health
3 care insurer, the member and the member's treating provider. The decision
4 by the independent review organization is a final administrative decision
5 pursuant to title 41, chapter 6, article 10 and, except as provided in
6 section 41-1092.08, subsection H, is subject to judicial review pursuant
7 to title 12, chapter 7, article 6. The health care insurer shall provide
8 any service or pay any claim determined to be covered and medically
9 necessary by the independent review organization for the case under review
10 regardless of whether judicial review is sought.

11 5. For cases involving an issue of coverage, within two business
12 days after receipt of all of the information prescribed in subsection C of
13 this section from the utilization review agent, the director shall
14 determine if the service or claim is or is not covered and if the adverse
15 decision made pursuant to section 20-2534 conforms to the utilization
16 review agent's utilization review plan and this article and shall ~~mail~~
17 SEND a notice of determination to the utilization review agent, the health
18 care insurer, the member and the member's treating provider.

19 L. Notwithstanding title 41, chapter 6, article 10 and section
20 12-908, if a party to a decision issued under this section seeks further
21 administrative review, the department shall not be a party to the action
22 unless the department files a motion to intervene in the action.

23 M. The independent review organization, the director or the office
24 of administrative hearings may not order the health care insurer to
25 provide a service or to pay a claim for a benefit or service that is
26 excluded from coverage by the contract.

27 N. The health care insurer shall provide any service or pay any
28 claim determined in a final administrative decision to be covered and
29 medically necessary for the case under review regardless of whether
30 judicial review is sought. Any proceedings before the office of
31 administrative hearings that involve an expedited external independent
32 review and that are subject to subsection K of this section shall be
33 promptly instituted and completed.

34 Sec. 29. Section 20-2609, Arizona Revised Statutes, is amended to
35 read:

36 20-2609. Policyholder reports

37 An insurer that delivers or issues for delivery in this state a
38 variable life insurance policy shall ~~mail~~ SEND the following reports to
39 each variable life insurance policyholder ~~at the policyholder's last known~~
40 ~~address:~~

41 1. Within thirty days after each anniversary of the policy, a
42 statement or statements of the cash surrender value, the death benefit,
43 any partial withdrawal or policy loan, any interest charge and any
44 optional payments that are allowed under the policy and that are computed
45 as of the policy anniversary date. The statement may be furnished within

1 thirty days after a specified date in each policy year if the information
2 contained in the statement is computed not more than sixty days before the
3 notice is ~~mailed~~ SENT. This statement shall state that the cash values
4 and the variable death benefit may increase or decrease according to the
5 investment experience of the separate account and shall prominently
6 identify any value that the statement describes and that may be recomputed
7 before the next statement required by this section. If the policy
8 guarantees that the variable death benefit on the next policy anniversary
9 date will not be less than the variable death benefit specified in the
10 statement, the statement shall be modified to indicate this policy
11 guarantee. In addition, the report must show the projected cash value and
12 cash surrender value, if different, as of one year from the end of the
13 period covered by the report. In determining the projected value, the
14 insurer shall assume that the planned periodic premiums, if any, are paid
15 as scheduled, that the guaranteed costs of insurance are deducted and that
16 the net return is equal to the guaranteed rate, or if there is no
17 guaranteed rate, is not greater than zero. If the projected value is less
18 than zero, the statement shall include a warning message that the policy
19 may be in danger of terminating without value in the next twelve months
20 unless additional premium is paid. For flexible premium policies, the
21 report shall contain a reconciliation of the change since the previous
22 report in cash value and cash surrender value, if different, because of
23 payments made, less deductions for expense charges, withdrawals,
24 investment experience, insurance charges and any other charges made
25 against the cash value.

26 2. An annual statement or statements, including:

27 (a) A summary of the financial statement of the separate account
28 that is based on the annual statement last filed with the director.

29 (b) The net investment return of the separate account for the last
30 year and, for each year after the first, a comparison of the investment
31 rate of the separate account during the last year with the investment rate
32 during prior years, up to a total of not less than five years if
33 available.

34 (c) A list of investments that are held by the separate account as
35 of a date not earlier than the end of the last year for which an annual
36 statement was filed with the director.

37 (d) Any charges that were levied against the separate account
38 during the previous year.

39 (e) A statement of any change in the investment objective and
40 orientation of the separate account, in any investment restriction or
41 material quantitative or qualitative investment requirement that applies
42 to the separate account or in the investment advisor of the separate
43 account.

1 3. For flexible premium policies, if the amounts that are available
2 under the policy on any policy processing day to pay the charges that are
3 authorized by the policy are less than the amount necessary to keep the
4 policy in force until the next following policy processing day, a report
5 that indicates the minimum payment that is required under the terms of the
6 policy to keep the policy in force and the length of the grace period for
7 the payment of that amount.

8 Sec. 30. Section 20-2637, Arizona Revised Statutes, is amended to
9 read:

10 20-2637. Reports

11 A. At least once in each contract year after the first contract
12 year, a company that issues individual variable annuities shall ~~mail~~ SEND
13 to the contract holder at the contract holder's last known address a
14 statement reporting the investments that are held in the separate account
15 as of a date not more than four months before the SENT date ~~of mailing~~.
16 The company shall submit annually to the director on a form prescribed by
17 the national association of insurance commissioners a statement of the
18 business of its separate account or accounts.

19 B. If payments under an annuity contract have not yet commenced the
20 statement shall contain either:

21 1. The number of accumulation units that are credited to the
22 contract and the dollar value of a unit.

23 2. The value of the contract holder's account.

APPROVED BY THE GOVERNOR JUNE 5, 2020.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 5, 2020.