

REFERENCE TITLE: **insurers; notices; methods of delivery**

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

## **SB 1040**

Introduced by  
Senator Livingston

### **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, 20-367.01, 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, 20-1693.05, 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~~ 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 20-367.01, Arizona Revised Statutes, is amended to  
2 read:

3           20-367.01. Appeals procedure

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

9           B. If a person is aggrieved by the application of a rating system,  
10 the person may send a written request to the workers' compensation appeals  
11 board established by section 20-367 to review the manner in which the  
12 rating system has been applied to the insurance afforded the aggrieved  
13 person. The aggrieved person or that person's representative may present  
14 the grievance before the board. A representative of the rating  
15 organization whose rating system is the subject of the appeal shall attend  
16 any hearing before the board pursuant to this section to explain that  
17 application of the rating system to the aggrieved person.

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

21           D. The appellant shall pay the cost to record the board's  
22 proceedings.

23           E. The board shall ~~mail~~ SEND a written notice of its decision to  
24 the aggrieved person. Within thirty days after the date the BOARD SENDS  
25 THE written notice of ~~the board's ITS decision is mailed by the board~~, the  
26 aggrieved person may appeal the action to the director. After a hearing  
27 held on at least ten days' written notice to the person and the rating  
28 organization or insurer, the director shall affirm, modify or reverse the  
29 board's decision. The person appealing the board's decision shall pay the  
30 costs of the transcript and record of the appeal to the director.

31           Sec. 6. Section 20-866, Arizona Revised Statutes, is amended to  
32 read:

33           20-866. Location of office; publications; grievance procedure

34           A. The principal office of a domestic society shall be located in  
35 this state. The meetings of the society's supreme governing body may be  
36 held in any state, district, province or territory in which the society  
37 has at least one subordinate lodge or in any other place that is  
38 determined by the supreme governing body. Business that is transacted at  
39 an out of state meeting is valid in all respects as if the meeting were  
40 held in this state. The minutes of the proceedings of the supreme  
41 governing body and the board of directors shall be in English.

42           B. A society may publish an official publication in which any  
43 notice, report or statement required by the society's laws to be given to  
44 its members is published. A required notice, report or statement shall be  
45 conspicuously printed in the publication. If the records of the society

1 show that two or more members have the same mailing address, an official  
2 publication that is ~~mailed~~ SENT to one member is deemed to be ~~mailed~~ SENT  
3 to all members at the same address unless a member requests a separate  
4 copy.

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

9 D. A society may establish grievance or complaint procedures by law  
10 or rule.

11 Sec. 7. Section 20-1108, Arizona Revised Statutes, is amended to  
12 read:

13 20-1108. Admissibility of application as evidence

14 A. ~~No~~ AN application for the issuance of any life or disability  
15 insurance policy or contract ~~shall be~~ IS NOT admissible in evidence in any  
16 action relative to such policy or contract, unless a true copy of the  
17 application was attached to or otherwise made a part of the policy when  
18 issued and delivered. This ~~provision shall~~ SUBSECTION DOES not apply to  
19 industrial life insurance policies.

20 B. If any policy of life or disability insurance delivered in this  
21 state is reinstated or renewed, and the insured or the beneficiary or  
22 assignee of the policy makes written request to the insurer for a copy of  
23 the application, if any, for such reinstatement or renewal, the insurer  
24 ~~shall~~, within thirty days after receipt of the request at its home office  
25 or at any of its branch offices, SHALL deliver or ~~mail~~ SEND to the person  
26 making the request a copy of the application. If the copy is not ~~so~~  
27 delivered or ~~mailed~~ SENT after having been requested, the insurer ~~shall be~~  
28 IS precluded from introducing the application in evidence in any action or  
29 proceeding based ~~upon~~ ON or involving the policy or its reinstatement or  
30 renewal.

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

38 Sec. 8. Section 20-1241.03, Arizona Revised Statutes, is amended to  
39 read:

40 20-1241.03. Duties of insurance producers

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

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

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

9           D. The applicant and the insurance producer shall sign the notice  
10 required under subsection C of this section. The insurance producer shall  
11 leave the signed notice with the applicant. If the notice is presented  
12 electronically, the insurer shall ~~mail~~ SEND the applicant a copy of the  
13 notice within three business days after the application is submitted to  
14 the insurer. In the notice the insurance producer and the applicant shall  
15 attest that the insurance producer either read the notice aloud or that  
16 the applicant did not wish the notice to be read aloud, in which case the  
17 producer need not have read the notice aloud.

18           E. The notice prescribed in subsection C of this section shall:

19           1. Identify each policy and contract proposed to be replaced by:

20           (a) Name of the insurer.

21           (b) Name of the insured or annuitant.

22           (c) Policy or contract number if available.

23           (d) Application or receipt number if the policy or contract number  
24 is not available.

25           2. Include a statement as to whether each policy or contract will  
26 be replaced or whether a policy will be used as a source of financing for  
27 the new policy or contract.

28           F. If the application for a new policy or contract is completed in  
29 any replacement transaction, the insurance producer shall give the  
30 applicant the original or a copy of all sales material at the time of the  
31 application for the new policy or contract. The insurance producer or  
32 insurer shall provide the applicant with a printed copy of any  
33 electronically presented sales material not later than at the time of  
34 policy or contract delivery.

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

39           1. Each document required by this section.

40           2. A statement identifying any preprinted or electronically  
41 presented company approved sales materials used.

42           3. Any individualized sales materials, including any illustrations  
43 related to the specific policy or contract purchased.



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

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

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

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

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

16           Sec. 10. Section 20-1631, Arizona Revised Statutes, is amended to  
17 read:

18           20-1631. Definition of motor vehicle; cancellation of or  
19 failure to renew coverage; limitations; limitation  
20 of liability; exceptions; insurance producers;  
21 definitions

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

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

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

30           3. Any motor vehicle with a load capacity of more than fifteen  
31 hundred pounds.

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

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

42           C. An insurer shall not cancel or refuse to renew a motor vehicle  
43 insurance policy solely because of the location of residence, age, race,  
44 color, religion, sex, national origin or ancestry of anyone who is an  
45 insured, except that an insurer may refuse to renew a motor vehicle

1 insurance policy if a named insured establishes a primary residence in a  
2 state other than ~~Arizona~~ THIS STATE.

3 D. An insurer shall not issue a motor vehicle insurance policy in  
4 this state unless the cancellation and renewal conditions of the policy or  
5 the endorsement on the policy includes the limitations required by this  
6 section. After a policy issued in this state has been in effect for sixty  
7 days, or if the policy is a renewal, effective immediately, the company  
8 shall not exercise its right to cancel the insurance afforded under the  
9 policy unless:

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

13 2. The insurance was obtained through fraudulent misrepresentation.

14 3. The named insured, any person who resides in the same household  
15 as the named insured and WHO customarily operates a motor vehicle insured  
16 under the policy or any other person who regularly and frequently operates  
17 a motor vehicle insured under the policy:

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

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

24 (c) Is or has been convicted during the thirty-six months  
25 immediately preceding the effective date of the policy or during the  
26 policy period of:

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

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

31 (iii) Leaving the scene of an accident.

32 (iv) Making false statements in an application for a driver  
33 license.

34 (v) Reckless driving.

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

39 5. The named insured, any person who resides in the same household  
40 as the named insured and WHO customarily operates a motor vehicle insured  
41 under the policy or any other person who regularly and frequently operates  
42 a motor vehicle insured under the policy uses a motor vehicle rated or  
43 insured under the policy as a private passenger motor vehicle regularly  
44 and frequently for commercial purposes.

1           6. ~~From and after February 29, 2016,~~ The named insured, any person  
2 who resides in the same household as the named insured and who customarily  
3 operates a motor vehicle insured under the policy or any other person who  
4 regularly and frequently operates a motor vehicle insured under the policy  
5 uses a motor vehicle rated or insured under the policy to provide  
6 transportation network services unless, while the driver is logged in to  
7 the transportation network company's digital network or software  
8 application to be a driver or is providing transportation network  
9 services, the named insured either:

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

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

14           7. The director determines that the continuation of the policy  
15 would place the insurer in violation of the laws of this state or would  
16 jeopardize the solvency of the insurer.

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

23           F. The company shall not cancel the insurance when a person other  
24 than the named insured has violated subsection D, paragraph 3 of this  
25 section, if the named insured in writing agrees to exclude as insured the  
26 person by name when operating a motor vehicle and further agrees to  
27 exclude coverage to the named insured for any negligence that may be  
28 imputed by law to the named insured arising out of the maintenance,  
29 operation or use of a motor vehicle by the excluded person. The written  
30 agreement that excludes coverage under a policy for a named individual is  
31 effective for each renewal of the policy by the insurer and remains in  
32 effect until the insurer agrees in writing to provide coverage for the  
33 named individual who was previously excluded from coverage.

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

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

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

42           3. Providing insurance only on an excess basis.

43           H. If a consumer purchases motor vehicle insurance coverage from an  
44 insurance producer licensed in this state, the insurance producer that  
45 owns the policy expiration shall remain the insurance producer of record

1 for that insured. ~~In the event~~ IF the insurer terminates the insurance  
2 producer's contract, the insurance producer shall continue to provide  
3 customary services to the insured. The insurer shall provide the  
4 insurance producer with a minimum degree of authority necessary to provide  
5 customary services to the insured and shall provide the same level of  
6 compensation for these services that were in effect ~~prior to~~ BEFORE the  
7 termination of the insurance producer contract.

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

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

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

13 3. The insured has supplied the insurer with a written request that  
14 its insurance producer of record be changed to another insurance producer  
15 of the insurer.

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

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

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

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

27 K. Notwithstanding any law to the contrary, if an insurer chooses  
28 to renew a policy, the issuance at renewal of revised policy provisions to  
29 modify an existing policy by adding coverages or policy provisions,  
30 modifying coverages or policy provisions or eliminating coverages or  
31 policy provisions is not a nonrenewal or cancellation of the policy if the  
32 modification of a basic coverage does not eliminate the essential benefit  
33 of that basic coverage. If the modification of the basic coverage  
34 eliminates the essential benefit of the basic coverage, the director shall  
35 order the insurer to remove the modification from the policy. This  
36 subsection does not allow the insurer, without the written consent of the  
37 insured, to eliminate the basic coverages of the policy or to reduce the  
38 monetary limits of any of the basic coverages of the policy that were  
39 selected and agreed on. If an insurer chooses to renew a policy, this  
40 subsection does not limit a policyholder from continuing to renew  
41 uninsured or underinsured motorist coverage pursuant to section 20-259.01.  
42 For the purposes of this subsection, "basic coverage" means any of the  
43 following:

44 1. Bodily injury coverage.

45 2. Property damage coverage.

- 1           3. Uninsured motorist coverage.
- 2           4. Underinsured motorist coverage.
- 3           5. Medical payments coverage.
- 4           6. Comprehensive coverage.
- 5           7. Collision coverage.

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

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

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

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

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

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

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

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

41           2. To qualify as a bona fide association pursuant to this  
42 subsection, the association shall meet all of the requirements of this  
43 paragraph. The association shall file a statement with the director at  
44 least thirty days before the commencement of the offer or sale of  
45 insurance as provided by this subsection verifying that the association

1 meets the requirements of this paragraph. The association shall update  
2 the filing required by this paragraph at least thirty days before the  
3 effective date of any material change in the information contained in the  
4 statement, ~~and~~ and shall file a separate notice with the director if the  
5 insurance described in the statement is no longer available through the  
6 association. The statement shall include the following information:

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

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

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

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

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

21 3. Membership fees collected by the bona fide association are not  
22 premiums of the insurer that issued the coverage unless the bona fide  
23 association:

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

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

32 4. If the membership fees constitute premiums pursuant to paragraph  
33 3 of this subsection, an insurer shall not refuse to renew a policy as  
34 otherwise ~~permitted~~ ALLOWED by this subsection.

35 N. An insurer or insurance producer shall not inquire on an  
36 application for a motor vehicle insurance policy whether the applicant,  
37 any person who resides in the same household as the applicant and WHO  
38 customarily operates a motor vehicle to be insured under the policy, ~~or~~  
39 any other person who regularly and frequently operates a motor vehicle to  
40 be insured under the policy has been nonrenewed by an insurer.

41 O. An insurer may issue an endorsement to a private passenger  
42 policy that expressly provides coverage for the provision of  
43 transportation network services, but that endorsement may not be treated  
44 as basic coverage as defined in subsection K of this section and any  
45 termination of the endorsement may not be treated as a modification of

1 basic coverage. An insurer may terminate the endorsement allowed by this  
2 subsection by giving advance notice of the termination. Any notice by the  
3 insurer to the policyholder to terminate the endorsement allowed by this  
4 subsection shall be ~~mailed~~ SENT to the named insured ~~by United States mail~~  
5 at least forty-five days before the effective date of the termination.  
6 The notice shall include an explanation to the named insured that the  
7 further provision of transportation network services following the  
8 effective date of the termination might subject the insured to  
9 cancellation or nonrenewal of the insured's private passenger motor  
10 vehicle policy.

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

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

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

22 20-1632. Cancellation, nonrenewal and reduction of limits for  
23 reasons other than nonpayment of premium; notices  
24 to insured; refund of unearned premium

25 A. A notice by the insurer to the policyholder of cancellation or  
26 reduction in the limits of liability or coverage for reasons other than  
27 nonpayment of premium shall be ~~mailed~~ SENT to the named insured ~~with the~~  
28 ~~insurer obtaining proof of mailing by United States certified mail, United~~  
29 ~~States post office certificate of mailing or first class mail using~~  
30 ~~intelligent mail barcode or another similar tracking method used or~~  
31 ~~approved by the United States postal service~~ at least ten days before the  
32 effective date of the cancellation or reduction in limits of liability or  
33 coverage. Notice of nonrenewal for reasons other than nonpayment of  
34 premium shall be ~~mailed~~ SENT at least forty-five days before the effective  
35 date of the nonrenewal. A notice under this ~~section~~ SUBSECTION shall  
36 include or be accompanied by all of the following:

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

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



1 religion, sex, sexual orientation, marital status, national origin,  
2 ancestry or driving record.

3 C. This section does not apply to policies being cancelled pursuant  
4 to section 6-1415. The grace period provided in such policies shall be  
5 satisfied by the ~~ten day~~ TEN-DAY notice of intent of the premium finance  
6 company to cancel the insurance contract unless the default is cured  
7 within the ~~ten day~~ TEN-DAY period.

8 D. For the purposes of this section, "grace period" means the  
9 period of time after the premium due date during which the policy remains  
10 in force without penalty even though the premium due has not been paid.

11 Sec. 13. Section 20-1653, Arizona Revised Statutes, is amended to  
12 read:

13 20-1653. Sending notice of cancellation or nonrenewal to  
14 insured; statement of grounds and facts on which  
15 cancellation or nonrenewal is based

16 All notices of cancellation or nonrenewal shall be in writing, shall  
17 be ~~mailed~~ SENT to the named insured ~~at the address shown in the policy or~~  
18 ~~to the last known address of the insured~~ and shall state, with respect to  
19 cancellation of policies in effect after the time limits specified in  
20 section 20-1652 and, in the case of nonrenewal of policies as specified in  
21 section 20-1654:

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

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

27 Sec. 14. Section 20-1654, Arizona Revised Statutes, is amended to  
28 read:

29 20-1654. Sending notice of intention not to renew to insured;  
30 time; term of policy

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

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

1           Sec. 15. Section 20-1656, Arizona Revised Statutes, is amended to  
2 read:

3           20-1656. Proof of sending as proof of notice

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

8           B. ANY METHOD OF PROOF RETAINED BY THE INSURER FOR SENDING A NOTICE  
9 OF CANCELLATION BY ANY METHOD OTHER THAN BY MAIL IS SUFFICIENT PROOF OF  
10 THE NOTICE REQUIRED BY THIS ARTICLE.

11          Sec. 16. Section 20-1674, Arizona Revised Statutes, is amended to  
12 read:

13          20-1674. Notice of cancellation; refund of unearned premium

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

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

36          Sec. 17. Section 20-1676, Arizona Revised Statutes, is amended to  
37 read:

38          20-1676. Notice of nonrenewal

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

41          B. ~~No~~ A nonrenewal of any policy of insurance to which this article  
42 applies is NOT effective unless the insurer ~~mails or electronically~~  
43 ~~delivers, consistent with the requirements of title 44, chapter 26,~~ SENDS  
44 a copy of the notice of nonrenewal to the insured's agent ~~and mails with~~  
45 ~~the insurer obtaining proof of mail by United States certified mail or~~

1 ~~first class mail using intelligent mail barcode or another similar~~  
2 ~~tracking method used or approved by the United States postal service~~  
3 ~~written notice to the named insured, at the address shown in the policy or~~  
4 ~~to the last known address of the insured,~~ at least forty-five days before  
5 the end of the policy period, of its intention not to renew the policy.  
6 The transfer of a policyholder between companies within the same insurance  
7 group or changes in deductibles, premium, amount of insurance or coverage  
8 are not refusals to renew.

9 C. Notice of nonrenewal is not required if either of the following  
10 occurs:

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

13 2. The named insured has obtained replacement coverage or has  
14 agreed in writing to obtain replacement coverage.

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

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

24 Sec. 18. Section 20-1677, Arizona Revised Statutes, is amended to  
25 read:

26 20-1677. Notice of premium or coverage changes

27 A. An insurer shall ~~mail or deliver~~ SEND to the named insured ~~at~~  
28 ~~the mailing address shown on the policy~~ written notice of A premium  
29 increase, change in deductible or reduction in limits or substantial  
30 reduction in coverage at least thirty days before the expiration date of  
31 the policy. If the insurer fails to provide the thirty days' notice, the  
32 coverage provided to the named insured remains in effect until notice is  
33 given or until the effective date of replacement coverage obtained by the  
34 named insured, whichever occurs first.

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

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

1           Sec. 19. Section 20-1678, Arizona Revised Statutes, is amended to  
2 read:

3           20-1678. Proof of notice

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

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

10          Sec. 20. Section 20-1693.05, Arizona Revised Statutes, is amended  
11 to read:

12          20-1693.05. Termination of portable electronics insurance;  
13 notice; cancellation

14          A. Notwithstanding any other law:

15           1. An insurer may terminate or otherwise change the terms and  
16 conditions of a portable electronics insurance policy only on providing  
17 the policyholder and enrolled customers with at least thirty days' notice.

18           2. If the insurer changes the terms and conditions of a policy, the  
19 insurer shall provide the vendor policyholder with a revised policy or  
20 endorsement and each enrolled customer with a revised certificate,  
21 endorsement, updated brochure or other evidence indicating that a change  
22 in the terms and conditions has occurred and that includes a summary of  
23 the material changes.

24          B. Notwithstanding subsection A, paragraph 1 of this section:

25           1. An insurer may terminate a customer's enrollment under a  
26 portable electronics insurance policy with fifteen days' notice for  
27 discovery of fraud or material misrepresentation in obtaining coverage or  
28 in the presentation of a claim.

29           2. An insurer may immediately terminate a customer's enrollment  
30 under a portable electronics insurance policy for any of the following  
31 reasons:

32           (a) Nonpayment of premium.

33           (b) If the enrolled customer ceases to have an active service with  
34 the vendor.

35           (c) If an enrolled customer exhausts the aggregate limit of  
36 liability, if any, under the terms of the portable electronics insurance  
37 policy and the insurer sends notice of termination to the enrolled  
38 customer within thirty calendar days after exhaustion of the limit. If  
39 notice is not timely sent, enrollment shall continue notwithstanding the  
40 aggregate limit of liability until the insurer sends notice of termination  
41 to the enrolled customer.

42          C. If a vendor terminates a portable electronics insurance policy,  
43 the vendor shall ~~mail or deliver~~ SEND written notice to each enrolled  
44 customer advising the enrolled customer of the termination of the policy  
45 and the effective date of termination. The written notice shall be ~~mailed~~

1 ~~or delivered~~ SENT to the enrolled customer at least thirty days before the  
2 termination.

3 D. If notice or correspondence with respect to a policy of portable  
4 electronics insurance is required pursuant to this section or is otherwise  
5 required by law, it shall be in writing and sent within the notice period,  
6 if any, specified in the statute or rule requiring the notice or  
7 correspondence. ~~Notwithstanding any other law, notices and correspondence~~  
8 ~~may be sent either by mail or by electronic means. If the notice or~~  
9 ~~correspondence is mailed, it shall be sent to the vendor at the vendor's~~  
10 ~~mailing address specified for such purpose and to its affected enrolled~~  
11 ~~customers' last known mailing addresses on file with the insurer. The~~  
12 ~~insurer or vendor shall maintain proof of mailing in a form authorized or~~  
13 ~~accepted by the United States postal service or other commercial mail~~  
14 ~~delivery service. If the notice or correspondence is sent by electronic~~  
15 ~~means, it shall be sent to the vendor at the vendor's electronic mail~~  
16 ~~address specified for such purpose and to its affected enrolled customers'~~  
17 ~~last known electronic mail addresses as provided by each enrolled customer~~  
18 ~~to the insurer or vendor, as applicable. For the purposes of this~~  
19 ~~section, an enrolled customer's provision of an electronic mail address to~~  
20 ~~the insurer or vendor is deemed to constitute consent to receive notices~~  
21 ~~and correspondence by electronic means.~~ The insurer or vendor, as  
22 applicable, shall maintain proof that the notice or correspondence was  
23 sent.

24 E. The supervising entity appointed by the insurer may send notice  
25 or correspondence that is required by this section, or that is otherwise  
26 required by law, on behalf of an insurer or vendor.

27 F. An enrolled customer may cancel enrollment for coverage under a  
28 portable electronics insurance policy at any time and the person paying  
29 the premium shall receive a pro rata refund or credit of any applicable  
30 unearned premium within sixty days after the insurer or vendor receives  
31 the notice of cancellation from the enrolled customer.

32 Sec. 21. Section 20-1694.02, Arizona Revised Statutes, is amended  
33 to read:

34 20-1694.02. Identity theft group insurance policy; premiums;  
35 cancellation; requirements

36 A. The group policyholder may pay the premium for an identity theft  
37 group insurance policy from monies contributed wholly by the group  
38 policyholder, wholly by the group members or jointly by the group  
39 policyholder and the group members.

40 B. The following requirements apply to the cancellation, nonrenewal  
41 or conditional renewal of coverage under an identity theft group insurance  
42 policy:

43 1. The policy shall be issued or renewed for a one-year policy  
44 period unless the policy provides for a longer policy period.

1           2. Except as provided in paragraph 3 of this subsection, an insurer  
2 may cancel the policy or any certificate issued under the policy only if  
3 the cancellation is based on one or more of the following:

4           (a) The nonpayment of premium if the notice of cancellation informs  
5 the group policyholder of the amount due.

6           (b) The conviction of a criminal offense arising out of acts  
7 increasing the hazard insured against.

8           (c) The discovery of fraud or material misrepresentation in  
9 obtaining the policy or in the presentation of a claim under the policy.

10           (d) After the policy is issued or after the last renewal date, the  
11 discovery of an act or omission or a violation of any policy condition  
12 that substantially and materially increases the hazard insured against and  
13 that occurred subsequent to the inception of the current policy period.

14           (e) A material change in the nature or extent of the risk that  
15 occurred after the issuance or last annual renewal anniversary date of the  
16 policy that causes the risk of loss to be substantially and materially  
17 increased beyond what was contemplated at the time the policy was issued  
18 or last renewed.

19           (f) A determination by the director that continuation of the  
20 present premium volume of the insurer would jeopardize that insurer's  
21 solvency or be hazardous to the interests of the policyholders of the  
22 insurer, its creditors or the public.

23           3. An individual group member's coverage under this article  
24 terminates on termination of the member's affiliation with the group  
25 policyholder that constitutes membership in the group.

26           4. An act or omission by a group member does not constitute the  
27 basis for cancellation of the group policy.

28           5. An insurer's cancellation, nonrenewal or conditional renewal of  
29 a group policy or any certificate issued under the policy shall set forth  
30 the specific reasons for cancellation, nonrenewal or conditional renewal  
31 and does not become effective until at least forty-five days, or twenty  
32 days if based on nonpayment of premium, after the insurer ~~mails or~~  
33 ~~delivers~~ SENDS written notice of the cancellation, nonrenewal or  
34 conditional renewal to the group policyholder ~~at the mailing address shown~~  
35 ~~in the policy~~ and to affected certificate holders ~~at each certificate~~  
36 ~~holder's last known mailing address~~. If authorized by the insurer, the  
37 group policyholder may ~~mail or deliver~~ SEND the notice to the certificate  
38 holder on behalf of the insurer.

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

1 D. If a group member sustains a loss pursuant to a stolen identity  
2 event that occurs before the effective date of the cancellation,  
3 nonrenewal or conditional renewal of a group policy or the cancellation,  
4 nonrenewal, conditional renewal or termination of a certificate, whether  
5 initiated by the insurer, group policyholder or group member, the loss  
6 remains covered as provided under the policy notwithstanding the  
7 cancellation, nonrenewal, conditional renewal or termination.

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

10 20-2110. Reasons for adverse underwriting decisions

11 A. In the event of an adverse underwriting decision the insurance  
12 institution or insurance producer responsible for the decision shall  
13 either provide the applicant, policyholder or individual proposed for  
14 coverage with the specific reason for the adverse underwriting decision in  
15 writing or advise the person, in writing, that ~~upon~~ ON written request the  
16 person may receive the specific reason in writing and provide the  
17 applicant, policyholder or individual proposed for coverage with a summary  
18 of the rights established under subsection B of this section and sections  
19 20-2108 and 20-2109.

20 B. ~~Upon~~ ON receipt of a written request within ninety business days  
21 ~~from~~ AFTER the date ~~of~~ the ~~mailing of~~ notice or other communication of an  
22 adverse underwriting decision IS SENT to an applicant, policyholder or  
23 individual proposed for coverage, the insurance institution or insurance  
24 producer shall ~~furnish~~ SEND to the person within twenty-one business days  
25 ~~from~~ AFTER the date of receipt of the written request:

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

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

31 (a) The insurance institution or insurance producer is not required  
32 to furnish specific items of privileged information if it has a reasonable  
33 suspicion, based ~~upon~~ ON specific information available for review by the  
34 director, that the applicant, policyholder or individual proposed for  
35 coverage has engaged in criminal activity, fraud, material  
36 misrepresentation or material nondisclosure.

37 (b) Specific items of medical record information supplied by a  
38 medical care institution or medical professional shall be disclosed either  
39 directly to the individual about whom the information relates or to a  
40 medical professional designated by the individual and licensed to provide  
41 medical care with respect to the condition to which the information  
42 relates, at the option of the insurance institution or insurance producer.

43 3. The names and addresses of the institutional sources that  
44 supplied the specific items of information pursuant to paragraph 2 of this  
45 subsection, except that the identity of any medical professional or

1 medical care institution shall be disclosed either directly to the  
2 individual or to the designated medical professional, whichever the  
3 insurance institution or insurance producer prefers.

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

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

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

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

16 2. The source of the consumer report and how the individual may  
17 obtain a copy of the consumer report.

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

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

25 1. The absence of credit history or the inability to determine the  
26 consumer's credit history unless the insurer's action is actuarially  
27 justified or the insurer treats the consumer as if the consumer had  
28 neutral credit information, as defined by the insurer.

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

31 3. A bankruptcy or a lien satisfaction that is more than seven  
32 years old.

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

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

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

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

3           20-2209. Claims-made policy; cancellation

4           A policy issued pursuant to this chapter may provide that the  
5 association may cancel any of its policies for the reasons specified in  
6 section 20-1673 or in the event of nonpayment of any premium assessment or  
7 other charge by ~~mailing or delivering~~ **SENDING** to the insured ~~at the~~  
8 ~~address shown in the policy~~ written notice at least ten days before the  
9 effective date of the cancellation.

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

12          20-2533. Denial; levels of review; disclosure; review process

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

18           1. An expedited medical review and expedited appeal pursuant to  
19 section 20-2534.

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

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

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

23          B. A health care insurer may offer additional levels of review  
24 other than the levels prescribed in subsection A of this section as long  
25 as the additional levels of review do not increase the time period  
26 limitations prescribed by this article.

27          C. At the time coverage is initiated, each health care insurer that  
28 operates in this state and whose utilization review system includes the  
29 power to affect the direct or indirect denial of requested medical or  
30 health care services or claims for medical or health care services shall  
31 include a separate information packet that is approved by the director  
32 with the member's policy, evidence of coverage or similar document. At  
33 the time coverage is renewed, each health care insurer shall include a  
34 separate statement with the member's policy, evidence of coverage or  
35 similar document that informs the member that the member can obtain a  
36 replacement packet that explains the appeal process by contacting a  
37 specific department and telephone number. A health care insurer shall  
38 also provide a copy of the information packet to the member or the  
39 member's treating provider on request and ~~to the member within five~~  
40 ~~business days after the date the appeal is initiated pursuant to section~~  
41 ~~20-2534, 20-2535 or 20-2536~~ **PROVIDE ACCESS TO A COPY OF THE INFORMATION**  
42 **PACKET ON ITS WEBSITE**. The information packet provided by the health care  
43 insurer shall include all of the following information:

44           1. A detailed description and explanation of each level of review  
45 prescribed in subsection A of this section and notice of the member's

1 right to proceed to the next level of review if the prior review is  
2 unsuccessful.

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

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

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

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

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

24 7. A notice that if the member participates in the process of  
25 review pursuant to this article the member waives any privilege of  
26 confidentiality of the member's medical records regarding any person who  
27 examined or will examine the member's medical records in connection with  
28 that review process for the medical condition under review.

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

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

33 10. The name and telephone number for the department of insurance  
34 AND FINANCIAL INSTITUTIONS consumer assistance office with a statement  
35 that the department of insurance AND FINANCIAL INSTITUTIONS consumer  
36 assistance office can assist consumers with questions about the health  
37 care appeals process.

38 D. At the time of issuing a denial, the health care insurer shall  
39 notify the member of the right to appeal under this article. A health  
40 care insurer that issues an explanation of benefits document shall satisfy  
41 this obligation by prominently displaying in the document a statement  
42 about the right to appeal. A health care insurer that does not issue an  
43 explanation of benefits document shall satisfy this obligation through  
44 some other reasonable means to assure that the member is apprised of the  
45 right to appeal at the time of a denial. A reasonable means that includes

1 giving the member's treating provider a form statement about the right to  
2 appeal shall require the treating provider to notify the member of the  
3 member's right to appeal.

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

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

14 G. If the member's complaint is an issue of medical necessity under  
15 the coverage document and not whether the claim or service is covered, the  
16 informal reconsideration shall be performed as prescribed by section  
17 20-2535 by a licensed health care professional. If the member's complaint  
18 is an issue of medical necessity under the coverage document and not  
19 whether the claim or service is covered, the expedited review or formal  
20 appeal shall be decided by a physician, provider or other health care  
21 professional as prescribed by section 20-2534 or 20-2536. Any external  
22 independent review shall be decided by a physician, provider or other  
23 health care professional as prescribed by section 20-2537.

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

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

30 20-2534. Expedited medical review; expedited appeal

31 A. Any member who is denied a request for a covered service may  
32 pursue an expedited medical review of that denial if the member's treating  
33 provider certifies in writing and provides supporting documentation to the  
34 utilization review agent that the time period for the informal  
35 reconsideration process and formal appeal process prescribed in sections  
36 20-2535 and 20-2536 is likely to cause a significant negative change in  
37 the member's medical condition at issue that is subject to the appeal.  
38 The treating provider's certification is not challengeable by the health  
39 care insurer. A health care insurer whose utilization review activities  
40 consist only of claims review for services already provided is not  
41 required to provide its members an expedited medical review or expedited  
42 appeal pursuant to this section. A health care insurer who conducts  
43 utilization review of claims in connection with services already provided  
44 is not required to provide its members an expedited medical review or  
45 expedited appeal of a claim related to a service already provided.

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

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

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

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

1 utilization review agent. Pursuant to the requirements of this  
2 subsection, the utilization review agent shall select the provider,  
3 physician or other health care professional who shall review the appeal  
4 and render the decision. If the utilization review agent, provider,  
5 physician or other health care professional denies the expedited appeal,  
6 the utilization review agent shall telephonically provide and ~~mail~~ SEND to  
7 the member and the member's treating provider a notice of the denial and  
8 of the member's option to immediately proceed to the external independent  
9 review prescribed in section 20-2537.

10 F. If the utilization review agent, provider, physician or other  
11 health care professional concludes that the covered service should be  
12 provided, the health care insurer is bound by the utilization review  
13 agent's decision.

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

16 20-2535. Informal reconsideration

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

29 B. The utilization review agent shall ~~mail~~ SEND a written  
30 acknowledgment to the member and the member's treating provider within  
31 five business days after the utilization review agent receives the request  
32 for informal reconsideration.

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

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

40 E. At any time during the informal reconsideration process, the  
41 utilization review agent may submit a request to the director to initiate  
42 an external independent review process pursuant to section 20-2537. At  
43 the same time that the utilization review agent submits the request to the  
44 director, the utilization review agent shall also render a written  
45 decision and shall send the written decision, including the criteria used

1 and the clinical reasons for that decision and any references to  
2 supporting documentation, to the member, the member's treating provider  
3 and the director.

4 F. If the utilization review agent does not submit a request to the  
5 director pursuant to subsection E of this section and at the conclusion of  
6 the informal reconsideration process the utilization review agent denies  
7 the covered service or the claim for the covered service, the utilization  
8 review agent shall provide the member and the treating provider with a  
9 written statement of the agent's decision and the criteria used and the  
10 clinical reasons for that decision, including any references to any  
11 supporting documentation and a notice of the option to proceed after the  
12 formal appeal process to an external independent review.

13 G. If the utilization review agent concludes that the covered  
14 service should be provided or the claim for a covered service should be  
15 paid, the health care insurer is bound by the utilization review agent's  
16 decision.

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

19 20-2536. Formal appeal

20 A. After any applicable informal reconsideration pursuant to  
21 section 20-2535, if the utilization review agent denies the member's  
22 request for a covered service, the member may appeal that adverse  
23 decision. The member shall ~~mail~~ SEND a written appeal to the utilization  
24 review agent within sixty days after receipt of the adverse decision. In  
25 the event of a denial of a claim for a service that has already been  
26 provided, the member may appeal that denial by filing a written appeal  
27 with the utilization review agent within ~~two years~~ ONE YEAR after receipt  
28 of the notice of the denial.

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

32 C. The member or the member's treating provider shall submit to the  
33 utilization review agent with the written formal appeal any material  
34 justification or documentation to support the member's request for the  
35 service or claim for a service.

36 D. If the member's complaint is an issue of medical necessity under  
37 the coverage document and not whether the service is covered, a provider,  
38 physician or other health care professional who is licensed pursuant to  
39 title 32, chapter 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an ~~out of~~  
40 ~~state~~ OUT-OF-STATE provider physician or other health care professional  
41 who is licensed in another state and who is not licensed in this state,  
42 who is employed or under contract with the utilization review agent and  
43 who is qualified in a similar scope of practice as a provider, physician  
44 or other health care professional licensed pursuant to title 32, chapter  
45 7, 8, 11, 13, 14, 16, 17, 19, 19.1 or 29 or an ~~out of state~~ OUT-OF-STATE

1 provider, physician or other health care professional who is licensed in  
2 another state and who is not licensed in this state and who typically  
3 manages the medical condition under appeal shall review the appeal and  
4 render a decision based on the utilization review plan adopted by the  
5 utilization review agent. Pursuant to the requirements of this  
6 subsection, the utilization review agent shall select the provider,  
7 physician or other health care professional who shall review the appeal  
8 and render the decision.

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

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

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

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

24 G. If at the conclusion of the formal appeal process the  
25 utilization review agent denies the appeal and the utilization review  
26 agent does not initiate the external independent review process, the  
27 utilization review agent shall provide the member with notice of the  
28 option to proceed to an external independent review pursuant to section  
29 20-2537.

30 H. If the utilization review agent concludes that the covered  
31 service should be provided or the claim for a covered service should be  
32 paid, the health care insurer is bound by the utilization review agent's  
33 decision.

34 Sec. 28. Section 20-2537, Arizona Revised Statutes, is amended to  
35 read:

36 20-2537. External independent review; expedited external  
37 independent review

38 A. If the utilization review agent denies the member's request for  
39 a covered service or claim for a covered service at both the informal  
40 reconsideration level and the formal appeal level, or at the expedited  
41 medical review level, the member may initiate an external independent  
42 review.

43 B. Except as provided in subsection K of this section, within four  
44 months after the member receives written notice by the utilization review  
45 agent of the adverse decision made pursuant to section 20-2534 or 20-2536,

1 if the member decides to initiate an external independent review, the  
2 member shall ~~mail~~ SEND to the utilization review agent a written request  
3 for an external independent review, including any material justification  
4 or documentation to support the member's request for the covered service  
5 or claim for a covered service.

6 C. Except as provided in subsection K of this section, within five  
7 business days after the utilization review agent receives a request for an  
8 external independent review from the member pursuant to subsection B of  
9 this section or the director pursuant to subsection G of this section, or  
10 if the utilization review agent initiates an external independent review  
11 pursuant to section 20-2536, subsection F, the utilization review agent  
12 shall:

13 1. ~~Mail~~ SEND a written acknowledgment to the director, the member,  
14 the member's treating provider and the health care insurer.

15 2. Forward to the director the request for review, the terms of  
16 agreement in the member's policy, evidence of coverage or a similar  
17 document and all medical records and supporting documentation used to  
18 render the decision pertaining to the member's case, a summary description  
19 of the applicable issues including a statement of the utilization review  
20 agent's decision, the criteria used and the clinical reasons for that  
21 decision, the relevant portions of the utilization review agent's  
22 utilization review plan and the name and credentials of the licensed  
23 health care provider who reviewed the case as required by section 20-2533,  
24 subsection G.

25 D. Except as provided in subsection K of this section, within five  
26 days after the director receives all of the information prescribed in  
27 subsection C, paragraph 2 of this section and if the case involves an  
28 issue of medical necessity under the coverage document, the director shall  
29 choose an independent review organization procured pursuant to section  
30 20-2538 and forward to the organization all of the information required by  
31 subsection C, paragraph 2 of this section.

32 E. Except as provided in subsection K of this section, for cases  
33 involving an issue of medical necessity under the coverage document,  
34 within twenty-one days after the date of receiving a case for independent  
35 review from the director, the independent review organization shall  
36 evaluate and analyze the case and, based on all information required under  
37 subsection C, paragraph 2 of this section, render a decision that is  
38 consistent with the utilization review plan on whether or not the service  
39 or claim for the service is medically necessary and send the decision to  
40 the director. Within five business days after receiving a notice of  
41 decision from the independent review organization, the director shall ~~mail~~  
42 SEND a notice of the decision to the utilization review agent, the health  
43 care insurer, the member and the member's treating provider. The decision  
44 by the independent review organization is a final administrative decision  
45 pursuant to title 41, chapter 6, article 10 and is subject to judicial

1 review pursuant to title 12, chapter 7, article 6. The health care  
2 insurer shall provide any service or pay any claim determined to be  
3 covered and medically necessary by the independent review organization for  
4 the case under review regardless of whether judicial review is sought.

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

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

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

21 1. To transmit, when necessary, a record of the proceedings to  
22 superior court or to the office of administrative hearings.

23 2. To issue a final administrative decision pursuant to section  
24 41-1092.08.

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

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

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

39 1. Within five business days after the member receives written  
40 notice by the utilization review agent of the adverse decision made  
41 pursuant to section 20-2534, if the member decides to initiate an external  
42 independent review, the member shall ~~mail~~ SEND to the utilization review  
43 agent a written request for an expedited external independent review,  
44 including any material justification or documentation to support the  
45 member's request for the covered service or claim for a covered service.

1           2. Within one business day after the utilization review agent  
2 receives a request for an expedited external independent review from the  
3 member pursuant to this subsection or if the utilization review agent  
4 initiates an expedited external independent review pursuant to section  
5 20-2534, subsection D, the utilization review agent shall:

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

8           (b) Forward to the director the request for an expedited  
9 independent external review, the terms of agreement in the member's  
10 policy, evidence of coverage or a similar document and all medical records  
11 and supporting documentation used to render the decision pertaining to the  
12 member's case, a summary description of the applicable issues including a  
13 statement of the utilization review agent's decision, the criteria used  
14 and the clinical reasons for that decision, the relevant portions of the  
15 utilization review agent's utilization review plan and the name and  
16 credentials of the licensed health care provider who reviewed the case as  
17 required by section 20-2534, subsection B.

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

23           4. For cases involving an issue of medical necessity, within  
24 seventy-two hours from the date of receiving a case for expedited external  
25 independent review from the director, the independent review organization  
26 shall evaluate and analyze the case and, based on all information required  
27 under subsection C, paragraph 2 of this section, render a decision that is  
28 consistent with the utilization review plan on whether or not the service  
29 or claim for the service is medically necessary and send the decision to  
30 the director. Within one business day after receiving a notice of  
31 decision from the independent review organization, the director shall ~~mail~~  
32 SEND a notice of the decision to the utilization review agent, the health  
33 care insurer, the member and the member's treating provider. The decision  
34 by the independent review organization is a final administrative decision  
35 pursuant to title 41, chapter 6, article 10 and, except as provided in  
36 section 41-1092.08, subsection H, is subject to judicial review pursuant  
37 to title 12, chapter 7, article 6. The health care insurer shall provide  
38 any service or pay any claim determined to be covered and medically  
39 necessary by the independent review organization for the case under review  
40 regardless of whether judicial review is sought.

41           5. For cases involving an issue of coverage, within two business  
42 days after receipt of all of the information prescribed in subsection C of  
43 this section from the utilization review agent, the director shall  
44 determine if the service or claim is or is not covered and if the adverse  
45 decision made pursuant to section 20-2534 conforms to the utilization

1 review agent's utilization review plan and this article and shall ~~mail~~  
2 SEND a notice of determination to the utilization review agent, the health  
3 care insurer, the member and the member's treating provider.

4 L. Notwithstanding title 41, chapter 6, article 10 and section  
5 12-908, if a party to a decision issued under this section seeks further  
6 administrative review, the department shall not be a party to the action  
7 unless the department files a motion to intervene in the action.

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

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

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

21 20-2609. Policyholder reports

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

26 1. Within thirty days after each anniversary of the policy, a  
27 statement or statements of the cash surrender value, the death benefit,  
28 any partial withdrawal or policy loan, any interest charge and any  
29 optional payments that are allowed under the policy and that are computed  
30 as of the policy anniversary date. The statement may be furnished within  
31 thirty days after a specified date in each policy year if the information  
32 contained in the statement is computed not more than sixty days before the  
33 notice is ~~mailed~~ SENT. This statement shall state that the cash values  
34 and the variable death benefit may increase or decrease according to the  
35 investment experience of the separate account and shall prominently  
36 identify any value that the statement describes and that may be recomputed  
37 before the next statement required by this section. If the policy  
38 guarantees that the variable death benefit on the next policy anniversary  
39 date will not be less than the variable death benefit specified in the  
40 statement, the statement shall be modified to indicate this policy  
41 guarantee. In addition, the report must show the projected cash value and  
42 cash surrender value, if different, as of one year from the end of the  
43 period covered by the report. In determining the projected value, the  
44 insurer shall assume that the planned periodic premiums, if any, are paid  
45 as scheduled, that the guaranteed costs of insurance are deducted and that

1 the net return is equal to the guaranteed rate, or if there is no  
2 guaranteed rate, is not greater than zero. If the projected value is less  
3 than zero, the statement shall include a warning message that the policy  
4 may be in danger of terminating without value in the next twelve months  
5 unless additional premium is paid. For flexible premium policies, the  
6 report shall contain a reconciliation of the change since the previous  
7 report in cash value and cash surrender value, if different, because of  
8 payments made, less deductions for expense charges, withdrawals,  
9 investment experience, insurance charges and any other charges made  
10 against the cash value.

11 2. An annual statement or statements, including:

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

14 (b) The net investment return of the separate account for the last  
15 year and, for each year after the first, a comparison of the investment  
16 rate of the separate account during the last year with the investment rate  
17 during prior years, up to a total of not less than five years if  
18 available.

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

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

24 (e) A statement of any change in the investment objective and  
25 orientation of the separate account, in any investment restriction or  
26 material quantitative or qualitative investment requirement that applies  
27 to the separate account or in the investment advisor of the separate  
28 account.

29 3. For flexible premium policies, if the amounts that are available  
30 under the policy on any policy processing day to pay the charges that are  
31 authorized by the policy are less than the amount necessary to keep the  
32 policy in force until the next following policy processing day, a report  
33 that indicates the minimum payment that is required under the terms of the  
34 policy to keep the policy in force and the length of the grace period for  
35 the payment of that amount.

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

38 20-2637. Reports

39 A. At least once in each contract year after the first contract  
40 year, a company that issues individual variable annuities shall ~~mail~~ SEND  
41 to the contract holder at the contract holder's last known address a  
42 statement reporting the investments that are held in the separate account  
43 as of a date not more than four months before the ~~of mailing~~ SENT date ~~of mailing~~.  
44 The company shall submit annually to the director on a form prescribed by

1 the national association of insurance commissioners a statement of the  
2 business of its separate account or accounts.

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

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

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