

(4) If the appropriation for a biennium is fully expended prior to the end of the biennium, political subdivisions should continue to submit claims for the purpose of providing justification for requests for adequate funding levels in future biennia.

(5) The department shall include in its biennial appropriation requests proposed rates based on studies of local government costs to be conducted biennially. [Statutory Authority: RCW 72.72.040, 81-15-061 (Order 1682), § 275-110-090, filed 7/20/81; 80-17-004 (Order 1569), § 275-110-090, filed 11/7/80; 80-02-109 (Order 1482), § 275-110-090, filed 1/25/80.]

Chapter 275-216 WAC

STATE INSTITUTIONS OTHER THAN ADULT CORRECTIONAL INSTITUTIONS--TRIAL VISIT TO COMMUNITY--RESIDENT NEEDING PUBLIC ASSISTANCE

WAC
275-216-010 through 275-216-020 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 275-216-010 Trial visits--Definitions. [Order 874, § 275-216-010, filed 11/16/73.] Repealed by 81-19-084 (Order 1699), filed 9/17/81. Statutory Authority: RCW 72.01.090.
- 275-216-020 Trial visits--Client needing public assistance--Institution's responsibility. [Order 874, § 275-216-020, filed 11/16/73.] Repealed by 81-19-084 (Order 1699), filed 9/17/81. Statutory Authority: RCW 72.01.090.

WAC 275-216-010 through 275-216-020 Repealed.
See Disposition Table at beginning of this chapter.

Title 284 WAC

INSURANCE COMMISSIONER

Chapters

- 284-12 Agents, brokers and adjusters.
284-14 Regulations pertaining to fees and taxes.
284-15 Surplus line insurance.
284-17 Licensing requirements and procedures.
284-20 Insurance policies.
284-24 Rates.
284-30 Trade practices.
284-44 Health care services contractors--Agents--
Contract formats--Standards.
284-50 Washington disability insurance advertising
regulations.
284-51 Standards for coordination of benefits.
284-55 Medicare supplemental health insurance
regulation.
284-58 Regulations pertaining to form filings.

Chapter 284-12 WAC

AGENTS, BROKERS AND ADJUSTERS

WAC
284-12-024 Repealed.
284-12-025 Repealed.
284-12-027 Repealed.
284-12-028 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-12-024 Waiver of unauthorized alien insurers' financial requirements. [Statutory Authority: RCW 48.02.060, 80-06-039 (Order R-80-6), § 284-12-024, filed 5/12/80.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-12-025 Brokers--Surplus line--Qualifications and examination. [Rule dated 1/20/58, filed 3/22/60.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-12-027 Form for surplus line insurer to designate person to receive legal process. [Statutory Authority: RCW 48-02.060, 79-11-079 (Order R 79-5), § 284-12-027, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-12-028 Surplus line brokers' form to be filed; contract stamp to be used. [Statutory Authority: RCW 48.02.060, 79-11-079 (Order R 79-5), § 284-12-028, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

WAC 284-12-024 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-12-025 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-12-027 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-12-028 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-14 WAC

REGULATIONS PERTAINING TO FEES AND TAXES

WAC
284-14-010 Filing fee for rates and forms.
284-14-020 Filing transmittal information.

WAC 284-14-010 Filing fee for rates and forms.
(1) Beginning November 15, 1982, the filing fee for filing insurance rates and the filing fee for filing insurance forms shall be fifteen dollars each per filing.

(2) The following definitions shall apply for the purpose of determining the proper filing fee:

(a) A rate filing is a submission at one time from one insurer or rating organization of manuals of classification and manuals of rules and rates, or any modification thereof, and rating schedules or rating plans or a request for a rate change or deviation for one or more contract forms which may logically be grouped together.

(b) A form filing pertaining to life or disability insurance is the submission at one time from one insurer of:

(i) Policy pages which define all the conditions pertaining to one basic insurance contract, together with its application if it is an integral part thereof and set forth therein; or

(ii) An application form for general use with one or more policy forms, except when it is an integral part of the policy pages and set forth therein; or

(iii) A rider form which provides optional benefits in addition to those of one or more basic insurance contracts; or

(iv) An endorsement or amendment form which alters the provisions of any insurance contract; or

(v) Any other form for general use attachable to or becoming part of an insurance contract.

(c) A form filing pertaining to all other types of insurance is the submission at one time from one insurer or rating organization of:

(i) A policy, meaning a basic contract of insurance, together with its application form, if any, or any other forms which may define, extend, limit, exclude, condition, or otherwise alter coverage under the policy; or

(ii) Each application form or other form or combination of forms, other than a policy, related to one policy or to more than one similar policies, such as a series of homeowners-type policies, which form or forms are designed to define, extend, limit, exclude, condition, or otherwise alter coverage under such policy or policies. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-010, filed 10/6/82.]

WAC 284-14-020 Filing transmittal information. Each rate or form filing, as defined by 284-14-010, shall be accompanied by a transmittal containing the following information:

- (1) Date of submission;
- (2) Company name;
- (3) Washington state company identification code (CIC);
- (4) National Association of Insurance Commissioners number;
- (5) Line of insurance and policy type, as appropriate, as follows:
 - (a) Life; individual or individual credit or individual separate account, group or group credit or group separate account;
 - (b) Annuity; individual or individual separate account, group or group separate account;
 - (c) Disability; individual or individual credit, group or group credit;
 - (d) Medicare supplement; individual or group;
 - (e) Property;
 - (f) Casualty;
 - (g) Other (explain);
- (6) Type of filing, indicating whether it is a:
 - (a) Rate filing; or
 - (b) Form filing. If a form filing, indicate:
 - (i) The form number and, if appropriate, the form number being replaced;
 - (ii) Whether the form is being filed for approval or as a certified filing;

(7) The name and telephone number of the company contact person.

Sample transmittal forms, that may be used in conjunction with company letterhead, are available from the office of insurance commissioner. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-020, filed 10/6/82.]

Chapter 284-15 WAC SURPLUS LINE INSURANCE

WAC	
284-15-010	Brokers—Surplus line—Qualifications and examination.
284-15-020	Surplus line broker—Solvent insurer required.
284-15-030	Surplus line brokers' form to be filed—Contract stamp to be used.
284-15-040	Form for surplus line insurer to designate person to receive legal process.
284-15-050	Surplus line—Waiver of financial requirements.

WAC 284-15-010 Brokers—Surplus line—Qualifications and examination. (1) Each applicant for initial license as a surplus line broker shall, prior to issuance of any such license, take and pass to the satisfaction of the commissioner an examination given by the commissioner. It shall be a test of his or her qualifications and competence in all areas of surplus line insurance. The examination shall be given in the same manner and under the same conditions as are prescribed for brokers in chapter 48.17 RCW, except that such surplus line examination will generally be given twice each year at times set by the commissioner.

(2) Minimum requirements to be met by an applicant before he or she will be permitted to take the examination are:

(a) An applicant must have been licensed as a casualty-property broker in accordance with RCW 48.17-.150 for not less than five years preceding the date of the application, or have received the Chartered Property Casualty Underwriter (CPCU) designation with not less than five years' experience in the insurance industry preceding the date of the application, or have not less than ten years' experience as an insurance company employee, or an employee of an insurance broker's office or other related insurance industry experience preceding the date of the application, or have other equivalent experience acceptable to the insurance commissioner.

(b) Such applicants shall complete application forms supplied by the commissioner.

(3) For the purpose of this regulation "applicant" and "surplus line broker" are defined to include any individual who is to be empowered and designated in the license as authorized to exercise the powers conferred thereby.

(4) The applicant, and each surplus line broker while so licensed, must be a resident of the state of Washington. [Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-010, filed 1/21/81.]

WAC 284-15-020 Surplus line broker--Solvent insurer required. (1) A surplus line broker shall not knowingly place surplus line insurance with financially unsound insurers.

Foreign and alien insurers must meet or exceed the minimum financial conditions required by RCW 48.15.090.

(2) A surplus line broker shall ascertain the financial condition of the unauthorized insurer and maintain written evidence thereof before placing insurance therewith.

(a) When the surplus line broker uses an alien unauthorized insurer shown on the National Association of Insurance Commissioners (NAIC) Quarterly Listing of Alien Insurers dated within three months of the placement of the risk, it shall be deemed that the insurer meets the financial requirements of RCW 48.15.090 and that its financial condition is adequately documented.

(b) When the surplus line broker uses an alien unauthorized insurer that is not shown on the NAIC Quarterly Listing of Alien Insurers, there must be documentation in the broker's files demonstrating that the requirements of subsection (1) of this section are met or exceeded.

This documentation shall include at least the following:

(i) A copy of the unauthorized insurer's most recent available annual financial statement. This shall include an English version with United States dollar equivalents; and

(ii) Any other information obtained by the broker that verifies the financial condition of the alien company.

(c) The surplus line broker must have at least the current NAIC annual statement or its equivalent on file for any foreign unauthorized insurer used. [Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-020, filed 1/21/81.]

WAC 284-15-030 Surplus line brokers' form to be filed--Contract stamp to be used. (1) RCW 48.15.040 requires that a surplus line broker execute an affidavit at the time of procuring insurance from an unauthorized insurer, and to file such affidavit with the commissioner within thirty days after the insurance is procured. The form for filing such affidavit shall be in substantially the following form, and may include additional information to satisfy requirements of the Surplus Line Association of Washington:

Policy or Certificate No: Premium, including any policy fee:

- 1. Name and license number of filing Surplus Line Broker:
2. Name and address of producing agent or broker (if any):
3. Name(s) of unauthorized insurer(s):
4. Name and address of insured:

5. Brief statement of coverages (common trade terms may be used, e.g. "furrier's block"):

STATE OF WASHINGTON) SURPLUS LINE
) ss. BROKER'S
----- County) AFFIDAVIT

I have procured insurance from an unauthorized insurer or insurers, in accordance with the laws and regulations of the state of Washington under my Surplus Line Broker's license. Details of such transaction are set forth above.

Such insurance could not be procured, after diligent effort was made to do so from among a majority of the insurers authorized to transact that kind of insurance in this state, and placing the insurance in such unauthorized insurer(s) was not done for the purpose of securing a lower premium rate than would be accepted by any authorized insurer.

I certify that I am duly authorized to place this coverage on behalf of the insured, that the risk has been duly accepted by the insurer(s), and that I ascertained the financial condition of the unauthorized insurer(s) before placing the insurance therewith.

(Signature of Surplus Line Broker)

Subscribed and sworn to before me this ----- day of -----, 19--

Notary Public in and for the State of Washington,
residing at -----

(2) Every insurance contract, including those evidenced by a binder, procured and delivered as a surplus line coverage pursuant to chapter 48.15 RCW shall have a conspicuous statement stamped upon its face, which shall be initialed by or bear the name of the surplus line broker who procured it, as follows:

"This contract is registered and delivered as a surplus line coverage under the insurance code of the state of Washington, enacted in 1947. It is not issued by a company regulated by the Washington state insurance commissioner and is not protected by any Washington state guaranty fund law."

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-030, filed 1/21/81.]

WAC 284-15-040 Form for surplus line insurer to designate person to receive legal process. (1) RCW 48.15.150 permits service of legal process against an unauthorized insurer that is sued upon any cause of action arising in this state under any contract issued by it as a surplus line contract to be made upon the insurance commissioner. The commissioner will mail the documents of process to the insurer at its principal place of business last known to the commissioner, or to a person designated by the insurer for that purpose in the most recent document filed with the commissioner on a form

prescribed by the commissioner. If such unauthorized insurer elects to designate a person to receive such legal process from the commissioner, the designation shall be filed with the commissioner in substantially the form set forth in subsection (2) of this section.

(2) DESIGNATION OF PERSON TO WHOM COMMISSIONER SHALL FORWARD LEGAL PROCESS.

To the Insurance Commissioner of the state of Washington:

Pursuant to RCW 48.15.150, the undersigned Insurer hereby designates:

Name -----
Address -----

as the person to whom the Insurance Commissioner shall forward legal process against the Insurer. This designation supersedes any similar designation heretofore made by this Insurer.

Executed at -----, this ----- day of -----, 19--

(Insurer)
By -----
(Title)

(3) The "person" designated may be an individual, firm or corporation.

(4) The commissioner shall forward process to the person designated in the most recent document filed with him.

(5) Pursuant to RCW 48.15.150, each policy issued by an unauthorized insurer as a surplus line contract must contain a provision designating the commissioner as the person upon whom service of process may be made. [Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-040, filed 1/21/81.]

WAC 284-15-050 Surplus line--Waiver of financial requirements. The commissioner may waive the financial requirements specified in RCW 48.15.090 in circumstances where insurance cannot be otherwise procured on risks located in this state. At least the following information shall be submitted when a surplus line broker makes a request for the commissioner to waive the financial requirements:

(1) A letter of explanation for the need to waive the financial requirements;

(2) The financial condition of the proposed insurer as reported in its annual statement as of the end of the calendar year next preceding;

(3) The number of years the company has been writing the specific class of insurance;

(4) The reinsurance agreements backing up the class of coverage or the company;

(5) Written acknowledgement signed by the proposed insured to the effect that the insured is informed that the coverage is to be issued by an insurer which is not an authorized insurer in the state of Washington; that financial requirements for surplus line insurers otherwise applicable have been waived by all parties concerned to enable this coverage to be obtained, and that there is no protection under the Washington Insurance Guaranty Association. [Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-050, filed 1/21/81.]

Chapter 284-17 WAC

LICENSING REQUIREMENTS AND PROCEDURES

Table with 2 columns: WAC and description. Rows include 284-17-100 Repealed, 284-17-110 Repealed, 284-17-120 Examination procedures for agents, solicitors and adjusters, 284-17-210 Definitions, 284-17-220 Continuing education requirement, 284-17-250 Courses conducted by authorized organizations, 284-17-270 Credit for courses, 284-17-310 When continuing education requirement must be met.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

Table with 2 columns: WAC and description. Rows include 284-17-100 Agent, solicitor or adjuster examination scheduling and fees. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-100, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060. 284-17-110 Reexamination after failure to pass examination. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-110, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060.

WAC 284-17-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-17-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-17-120 Examination procedures for agents, solicitors and adjusters. (1) The commissioner has contracted with an independent testing service for the administration of agents', solicitors', and adjusters' examinations. On and after June 1, 1982, any person desiring to take an examination for the type of license shown in subsection (2) of this section will be required to submit a registration form and the appropriate examination fee to educational testing service. Such fee is not refundable. Registration forms and information about examinations may be obtained from the office of insurance commissioner or from educational testing service.

(2) At least twice each month at predetermined locations, educational testing service will conduct the examinations required for the following types of licenses:

Table with 2 columns: TYPE OF LICENSE REQUIRED and EXAMINATION(S). Rows include Life Insurance Agent or Solicitor (Life), Disability Insurance Agent or Solicitor (Disability), Life and Disability Agent or Solicitor (Life, Disability), Property/Casualty Agent or Solicitor (Property, Casualty).

TYPE OF LICENSE REQUIRED	EXAMINATION(S)
General Lines Agent or Solicitor	Property, Casualty, Disability
All Lines Agent or Solicitor	Life, Disability, Property, Casualty
Vehicle Only Agent or Solicitor	Vehicle
Surety Only Agent or Solicitor	Surety
Credit Life & Disability Agent or Solicitor	Credit life and Disability
Independent Adjuster	Independent Adjuster
Public Adjuster	Public Adjuster

(3) If an applicant fails to take a scheduled examination, a new registration form and appropriate fees must be submitted for any later examination, unless a serious emergency prevented attendance.

(4) Tests for vehicle, surety, and credit insurance and for adjusters will be graded by the insurance commissioner's licensing department which will notify applicants of the results. Other tests will be graded by educational testing service which will provide each applicant with a score report, following examination. If the examination is passed, the score report must be forwarded to the insurance commissioner with a completed insurance license application, finger print card and the appropriate license fee.

(5) An applicant who fails to pass the insurance agent, solicitor or adjuster examination may request re-examination at such time as the applicant believes that he or she has completed sufficient additional study. Each reexamination request must be accompanied by a new registration form and the appropriate examination fee. [Statutory Authority: RCW 48.02.060, 82-10-016 (Order R 82-2), § 284-17-120, filed 4/28/82.]

WAC 284-17-210 Definitions. As used in this continuing education regulation, unless the context requires otherwise;

(1) "Course" includes courses, programs of instructions, correspondence courses and seminars.

(2) "Hours" means the time assigned by the commissioner as recognition for the satisfactory completion of an approved course. For college level work entirely on approved subjects:

(a) Twelve hours will be assigned for each quarter "credit hour."

(b) Sixteen hours will be assigned for each semester "credit hour." The number of hours assigned for other programs will normally be based upon the number of classroom contact hours or their equivalent. However, based upon the evaluation of the course content, the number of hours assigned may be less than the total amount of time spent by the student in the course.

(3) "Licensee" means each natural person licensed as a resident insurance agent, solicitor or broker to sell life, disability, property, or casualty insurance. A credit insurance licensee is not included.

(4) "Certificate of completion" means a document signed by the course instructor or other responsible officer which shall signify satisfactory completion of the course and shall reflect hours of credit earned. Such certificates shall be in standard form as prescribed by the insurance commissioner. [Statutory Authority: RCW

48.02.060, 82-10-016 (Order R 82-2), § 284-17-210, filed 4/28/82. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10, 80-04-042 (Order R 80-3), § 284-17-210, filed 3/20/80.]

WAC 284-17-220 Continuing education requirement. (1) The number of hours course work required to be presented annually as a prerequisite to license renewal or reissuance shall be 12 hours.

New licensees that have been licensed for less than 6 months at the time of renewal will not be required to complete the continuing education, however anyone licensed 6 months or more at time of renewal must have completed the entire 12 hours.

The commissioner may accept licensed sales experience in another state, as comparable experience for the purpose of calculating the number of years licensed and for determining the number of continuing education hours required for each annual renewal or reissuance.

Each course to be applied toward satisfaction of the continuing education requirement must have been completed within the twenty four month period immediately preceding the licensee's assigned license renewal date and hours applied cannot have been applied in a previous year toward satisfaction of the continuing education requirement.

(2) The courses participated in and for which credit is received shall be reported to the commissioner as part of the application for license renewal and shall be subject to verification.

(3) If the home state of a nonresident agent is determined to have a continuing education program substantially comparable to that of Washington, satisfaction of the continuing education requirement of the home state may be accepted as meeting Washington's requirement. [Statutory Authority: RCW 48.02.060 and 48.17.150, 81-18-049 (Order R 81-5), § 284-17-220, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10, 80-04-042 (Order R 80-3), § 284-17-220, filed 3/20/80.]

WAC 284-17-250 Courses conducted by authorized organizations. (1) Insurance companies, insurance trade associations and statewide associations of agents or brokers that have an existing formal, and demonstrable, training program may, upon request to and approval by the commissioner, be authorized to develop course content and conduct courses without the requirement for prior individual course review and approval by the commissioner.

(2) Local chapters of such an authorized statewide association of agents or brokers may submit proposed courses to the statewide organization and, upon a determination by the statewide organization that the local chapter's course meets the standards of the organization and complies with this continuing education regulation, such local chapter's course shall be considered to be a course of the statewide association of agents or brokers and shall be presumed to be approved by the commissioner.

(3) It is the intent of this section that only organizations with a formal, full-time training program be approved to develop and conduct courses without prior individual course approval. Courses of other organizations are to be reviewed and acted on by the commissioner on a prior and individual basis.

(4) Requests for training program review, and authority to develop course content and to conduct courses without prior individual course approval must include the following information:

(a) The name of the organization.

(b) A description of the existing training program of the organization including:

(i) The titles or description of courses taught during the previous year.

(ii) The number of students taught, by course, during the previous year.

(iii) The name of the person in charge of the training program, years of full-time training program experience and years with the present organization.

(iv) Budget of the training program for the current year.

(c) A description of the manner in which courses will be developed and reviewed prior to course conduct.

(d) A statement by the responsible employee or officer of the organization agreeing to comply with regulations in developing courses and attributing hours to courses.

(e) An agreement to offer to provide, and to provide when requested, a certificate of completion and hours earned to each successful student.

(f) An agreement to maintain records of student course completion for three years.

(5) The granting of authority to an organization to develop course content and conduct courses without prior individual course approval shall be for an indefinite period, or until revoked by the commissioner. The actual conduct and performance of the training program shall be subject to review by the commissioner.

(6) Organizations that have been authorized to develop course content and conduct courses without prior individual course approval shall file a course outline for each course with the commissioner. The course outline shall include:

(a) A description of the subject matter to be taught.

(b) The method of teaching or presentation.

(c) The number of classroom contact hours.

(d) An explanation of the criteria to be applied in determining whether the course is satisfactorily completed.

(e) The number of continuing education hours credit assigned.

(f) Other relevant information.

(7) Assignment of hours to courses by organizations that have been authorized to develop course content and conduct courses without prior individual approval shall be subject to review and revision by the commissioner as necessary to ensure consistency in continuing education hours assigned to comparable courses. [Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-250, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979

ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-250, filed 3/20/80.]

WAC 284-17-270 Credit for courses. (1) No course shall be established for less than one hour of continuing education credit. Courses conducted in conjunction with other meetings must have a separate continuing education course component.

(2) The instructor of a course must maintain a positive attendance record, consisting of a sign in - sign out register, in order to qualify the course for continuing education credit.

(3) The instructor of a course shall receive twice the number of hours credit for teaching a course as is allowed for a student taking the course. [Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-270, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-270, filed 3/20/80.]

WAC 284-17-310 When continuing education requirement must be met. Each licensee, as defined in WAC 284-17-210(3), shall be required to present evidence of completing the continuing education requirement, prior to license renewal, beginning with those license renewals falling due on or after October 1, 1981. [Statutory Authority: RCW 48.02.060. 82-10-016 (Order R 82-2), § 284-17-310, filed 4/28/82. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-310, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-310, filed 3/20/80.]

Chapter 284-20 WAC INSURANCE POLICIES

WAC

284-20-005

Repealed.

284-20-006

Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-20-005

Washington Insurance Examining Bureau, Inc.—Rates and adhering to filings. [Statutory Authority: RCW 48.02.060. 80-04-018 (Order R 80-2), § 284-20-005, filed 3/13/80; Order R-68-4, § 284-20-005, filed 7/3/68, effective 9/1/68; Order 179, filed 3/10/64; Original Order 179, filed 1/8/63.] Repealed by 82-02-024 (Order R 81-9), filed 12/30/81. Statutory Authority: RCW 48.02.060.

WAC 284-20-005 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-20-006 Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings.

(1) In performing the duty of ascertaining that lawful premiums are being charged, the commissioner finds that it is not reasonable or necessary, with regard to any kind of insurance, to mandate that data relating to all

policies issued be submitted for examination. He does find, however, that as to all kinds of insurance falling within the scope of chapter 48.19 RCW occasions may arise where, in order to ascertain that lawful rates are being charged, documents with respect to certain policies should be submitted for examination, and that such required submission should, in some instances, be on a random audit basis, and in some instances, by designation of certain specific policies.

(2) Based on the foregoing and pursuant to RCW 48.19.410, with respect to policies having an effective date on and after February 1, 1982, every insurer authorized to write property or casualty insurance in the state of Washington:

(a) May submit to the Washington Insurance Examining Bureau, Inc., for examination, any policies and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, which relate to property insurance as defined in RCW 48.11.040;

(b) Shall make available to the Washington Insurance Examining Bureau, Inc. a specifically identified policy and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, when directed to do so by the commissioner; and

(c) Shall make available to the Washington Insurance Examining Bureau, Inc. such policies and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, as may be required by the commissioner for purposes of random audits designed to test the companies' adherence to rate filings. [Statutory Authority: RCW 48.02.060. 82-02-024 (Order R 81-9), § 284-20-006, filed 12/30/81.]

Chapter 284-24 WAC RATES

WAC	
284-24-010	Repealed.
284-24-015	Statistical plans and designation of statistical agents.
284-24-020	Repealed.
284-24-030	Repealed.
284-24-035	Repealed.
284-24-040	Repealed.
284-24-050	Repealed.
284-24-060	Modification of filing requirements.
284-24-070	Suspension of filing requirements—"A" rating.
284-24-080	Rate filings required for certain inland marine risks.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-24-010	Statistical plans—Reporting loss and expense experience. [General Bulletin, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-020	Organizations designated as statistical agents. [General Bulletin, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-030	Nonsubscribing and nonmember carriers—Duties. [General Bulletin, filed 3/22/60.] Repealed by 82-

06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.

284-24-035 Exempt insurance carriers. [General Bulletin of 5/1/49, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.

284-24-040 Allocating indivisible premiums—"Homeowners policies." [Rule made 11/30/55, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.

284-24-050 Catastrophe coverage. [Rule made 7/23/51, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.

WAC 284-24-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-015 Statistical plans and designation of statistical agents. Pursuant to the provisions of RCW 48.19.370, the insurance commissioner has adopted the following statistical plans for the recording and reporting of loss and expense experience, and hereby designates the particular organizations, or their successors, as statistical agents to assist the commissioner in the gathering and compilation of experience for the classes of business stated.

(1) The statistical plans of the insurance services office with respect to the following kinds of insurance:

- (a) Fire and allied lines,
- (b) Automobile physical damage,
- (c) Automobile liability,
- (d) General liability,
- (e) Burglary,
- (f) Glass,
- (g) Boiler and machinery,
- (h) Inland marine,
- (i) Homeowners, comprehensive dwelling and dwelling policy program,
- (j) Commercial multi-peril,
- (k) Businessowners, and
- (l) Medical professional liability.

(2) The statistical plans of the National Association of Independent Insurers with respect to:

- (a) Burglary,
- (b) Businessowners,
- (c) Crop hail,
- (d) Farmowners,
- (e) Fidelity and surety,
- (f) Fire and allied lines,
- (g) General liability,
- (h) Glass,
- (i) Inland marine,
- (j) Malpractice and professional liability,
- (k) Personal lines (homeowners and dwelling fire),
- (l) Special multi-peril,
- (m) Automobile liability, and
- (n) Automobile physical damage.

(3) The statistical plans of the American Association of Insurance Services with respect to:

- (a) Homeowners,
- (b) Farmowners,
- (c) Mobile homeowners,
- (d) Inland marine,
- (e) Farm fire,

- (f) Dwelling fire,
 - (g) Commercial fire,
 - (h) General liability,
 - (i) Burglary,
 - (j) Glass,
 - (k) Special multi-peril,
 - (l) Manufacturers output, and
 - (m) Businessowners.
- (4) The statistical plan of the Surety Association of America with respect to fidelity, surety and forgery.
- (5) The statistical plan of the Crop-Hail Insurance Actuarial Association with respect to hail insurance on growing crops and windstorm (when accompanied by hail) insurance on growing crops.
- (6) The statistical plan of the Factory Mutual Service Bureau with respect to property insurance.
- (7) The statistical plan of the Mill and Elevator Rating Bureau with respect to property insurance.
- (8) The statistical plan of the Nuclear Insurance Rating Bureau with respect to nuclear physical damage insurance.

Experience filed by individual carriers is to be kept confidential by these statistical agents and only the consolidated experience will be available as public information. [Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-015, filed 3/1/82.]

WAC 284-24-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-035 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-040 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-050 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-24-060 Modification of filing requirements. (1) Pursuant to RCW 48.19.080, the commissioner rules and hereby orders that the rate filing requirements set forth in chapter 48.19 RCW are modified so that an insurer, having made its rates in full compliance with the requirements of such chapter, may use such rates immediately after it has made its filing thereof with the commissioner, with respect to the following kinds of insurance policies:

- (a) Property insurance policies, other than
 - (i) Homeowners and tenants policies, and
 - (ii) Dwelling fire and allied lines insurance on one to four family units, or fire insurance on individual dwelling contents.
- (b) Casualty insurance policies, other than
 - (i) Vehicle insurance which provides coverage on motor homes, private passenger or station wagon type vehicles or four-wheel motor vehicles with a load capacity of fifteen hundred pounds or less, which vehicles are not part of a fleet and are used principally for personal or

family needs, and motorcycles not used for commercial purposes,

- (ii) Policies covering mobile homes, travel trailers and/or their contents, and
- (iii) Professional liability insurance policies.
- (c) Surety insurance policies or bonds.
- (d) Marine and transportation insurance policies, other than
 - (i) Boatowners' insurance policies, and
 - (ii) Inland marine insurance policies covering personal property primarily intended for personal, family or household use, such as cameras, golfer's equipment, silverware, personal jewelry and personal articles.

(2) For purposes of this section the terms "dwelling units" and "dwelling buildings" include mobile homes. [Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-060, filed 3/1/82.]

WAC 284-24-070 Suspension of filing requirements—"A" rating. (1) Pursuant to RCW 48.19.080, the commissioner rules and hereby orders that the casualty insurance rate filing requirements set forth in chapter 48.19 RCW are suspended as to classes of policies:

- (a) Covering risks in a class, which risks are so different from each other that no single manual rate could be representative of all,
- (b) Covering risks of a classification that does not develop enough experience to warrant any creditability for ratemaking purposes, or
- (c) Covering risks that involve a new product or coverage as to which there is no appropriate analogy to similar exposures for ratemaking purposes.

(2) A rate filing for such classes of policies shall consist only of a notation, in an appropriate rate manual, of the symbol "(a)" following the description of the risk, which symbol shall indicate that the risk cannot practically be filed with the commissioner and that such risk shall be submitted to the insurer for rating.

(3) The insurer's rating of such a risk shall be based on a documented underwriting analysis of:

- (a) Specific definable loss potential characteristics,
 - (b) Analogy to similar exposures, and
 - (c) Available loss frequency and severity data.
- (4) Examples of appropriate "(a)" rated risks include but are not limited to:

- (a) Manufacturing and construction risks, such as:
 - (i) Ammunition manufacturing,
 - (ii) Dam construction,
 - (iii) Irrigation works operation, and
 - (iv) Logging railroad—operation and maintenance.
- (b) Owners, landlord and tenants risks, such as:
 - (i) Amusement devices, designed for small children only, not otherwise classified (NOC),
 - (ii) Christmas tree lots—open air,
 - (iii) Bleachers or grandstands,
 - (iv) Dude ranches,
 - (v) Firing ranges—indoor,
 - (vi) Parks or playgrounds, and
 - (vii) Zoos.
- (c) Product risks, such as:
 - (i) Aircraft or aircraft parts manufacturing,

- (ii) Ball or roller bearing manufacturing,
- (iii) Chemical manufacturing—household—NOC,
- (iv) Discontinued operations—products,
- (v) Electronic component manufacturing,
- (vi) Firearms manufacturing—over .50 caliber
- (vii) Instrument manufacturing—NOC,
- (viii) Levee construction,
- (ix) Machinery or machinery parts manufacturing,
- (x) Pharmaceutical or surgical goods manufacturing,
- (xi) Products—NOC,
- (xii) Sign manufacturing—NOC,
- (xiii) Tank manufacturing—metal—not pressurized,
- (xiv) Textile coating or impregnating,
- (xv) Tool manufacturing—hand type—powered,
- (xvi) Valves manufacturing,
- (xvii) Wheels manufacturing,
- (xviii) Wire goods manufacturing—NOC, and
- (xix) Wood products manufacturing—NOC.

(5) Insurers writing "(a) rated risks" shall maintain separate documentation, including loss experience, on each risk written and shall be prepared to provide such documentation to the insurance commissioner upon request. [Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-070, filed 3/1/82.]

WAC 284-24-080 Rate filings required for certain inland marine risks. RCW 48.19.030 and 48.19.070 recognize that certain inland marine risks are by general custom of the business not written according to manual rates or rating plans. The following inland marine classes of risks are, however, by general custom of the business written according to manual rates or rating plans, and, therefore, manual rates or rating plans applicable to the following such risks shall be filed with the commissioner and may be used immediately after filing except as otherwise provided in WAC 284-24-060(1)(d)(ii):

- (1) Accounts receivable and valuable papers and records,
- (2) Agricultural machinery, farm equipment and live-stock floaters,
- (3) Bicycle floater,
- (4) Cameras,
- (5) Camera and musical instrument dealers,
- (6) Equipment dealers,
- (7) Hardware and implement dealers floater,
- (8) Implement dealers stock floater,
- (9) Fine arts (private collections),
- (10) First class mail,
- (11) Floor plan,
- (12) Furriers' block,
- (13) Furriers' customers,
- (14) Garment contractors,
- (15) Golfer's equipment floater,
- (16) Musical instruments,
- (17) Negative film floater,
- (18) Neon signs,
- (19) Personal articles floater,
- (20) Personal effects,
- (21) Personal furs or fur floater,
- (22) Personal jewelry or jewelry floater,

- (23) Personal property floater,
- (24) Physicians' and surgeons' equipment floater,
- (25) Registered mail,
- (26) Silverware floater,
- (27) Stamp and coin collection floater,
- (28) Theatrical floater,
- (29) Tourist baggage,
- (30) Travel baggage (issued in combination with accident and sickness insurance), and
- (31) Wedding presents. [Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-080, filed 3/1/82.]

Chapter 284-30 WAC TRADE PRACTICES

WAC

284-30-005	Repealed.
284-30-010	Repealed.
284-30-100	Repealed.
284-30-110	Repealed.
284-30-120	Repealed.
284-30-130	Repealed.
284-30-140	Repealed.
284-30-150	Repealed.
284-30-160	Repealed.
284-30-170	Repealed.
284-30-180	Repealed.
284-30-190	Repealed.
284-30-200	Repealed.
284-30-990	Repealed.
284-30-991	Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-30-005	Which regulation applicable. [Order R-71-1, § 284-30-005, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-010	Replacement of life insurance policies. [Order R-68-10, § 284-30-010, filed 10/25/68; Order R-68-1 (part), § 284-30-010, filed 4/23/68, effective 10/1/68.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-100	Title and explanation. [Order R-71-1, § 284-30-100, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-110	Purpose. [Order R-71-1, § 284-30-110, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-120	Replacement of life insurance defined. [Order R-71-1, § 284-30-120, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-130	Exemptions. [Order R-71-1, § 284-30-130, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-140	Duties of licensees. [Order R-71-1, § 284-30-140, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-150	Duties of insurers. [Order R-71-1, § 284-30-150, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-30-160	Enforcement. [Order R-71-1, § 284-30-160, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038

- (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-170 Forms. [Order R-71-1, § 284-30-170, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-180 Supersedes prior regulation. [Order R-71-1, § 284-30-180, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-190 Severability. [Order R-71-1, § 284-30-190, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-200 Effective date. [Order R-71-1, § 284-30-200, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-990 Exhibit 1—Disclosure statement. [Exhibit 1 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-990), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-991 Exhibit 2—Notice to applicants regarding replacement of life insurance. [Exhibit 2 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-991), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

WAC 284-30-005 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-010 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-120 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-130 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-140 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-150 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-160 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-170 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-190 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-200 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-990 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-30-991 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-44 WAC

HEALTH CARE SERVICES CONTRACTORS— AGENTS—CONTRACT FORMATS—STANDARDS

WAC

- 284-44-045 Benefits for registered nurses' services.
- 284-44-060 Repealed.
- 284-44-100 Authority and purpose.
- 284-44-110 Applicability and scope.
- 284-44-120 Definitions.
- 284-44-130 When filing is required.
- 284-44-140 General contents of all filings.
- 284-44-150 Experience records.
- 284-44-160 Evaluating experience data.
- 284-44-170 Minimum required anticipated loss ratio.
- 284-44-180 Repealed.
- 284-44-190 Unique contract forms.
- 284-44-200 Effective date.
- 284-44-210 "Filing document" form—Standard contract filing information.
- 284-44-220 "Filing document" form—Nonstandard contract filing information.
- 284-44-250 Accounting method.
- 284-44-300 Purpose and applicability.
- 284-44-310 Agreement underwritten by insurance.
- 284-44-320 Agreement guaranteed by a surety company.
- 284-44-330 Agreement guaranteed by a deposit of cash or securities.
- 284-44-340 Modification of amount of reimbursement or indemnity.
- 284-44-350 Records and reporting.
- 284-44-360 Effective date.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-44-060 Minimum filing requirements. [Order R-74-1, § 284-44-060, filed 6/4/74, effective 8/1/74.] Repealed by 81-15-070 (Order R 81-3), filed 7/21/81, effective 10/1/81. Statutory Authority: RCW 48.44.050.
- 284-44-180 Contract forms excluded from minimum loss ratio requirements. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-180, filed 7/21/81, effective 10/1/81.] Repealed by 82-12-032 (Order R 82-3), filed 5/26/82. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1.

WAC 284-44-045 Benefits for registered nurses' services. (1) Every health care service contractor agreement which is entered into initially or renewed after the effective date of this rule, and which provides benefits for any health care service to be performed by doctors of medicine, and every certificate issued thereunder, shall contain the following provision, or a provision which is the substantial equivalent of it:

"Benefits under this contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of

such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW."

(2) The provisions of subsection (1) shall apply to all health care service agreements, whether they expressly provide for indemnification benefits for services rendered by health care providers who are not "participants" as defined in RCW 48.44.010(4), or whether they provide only for benefits in the form of services rendered by health care providers who are "participants" for the purpose of such contracts.

(3) To comply with RCW 48.44.290, benefits must not be denied to a person covered by a health care service agreement by reason of his choice to obtain health care services from a registered nurse. A unilaterally imposed contract provision which requires or permits an artificial reduction in the level of an indemnification benefit based on such a choice to obtain health care services from a registered nurse will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020(2)(f). An example of such an impermissible provision would be one which unilaterally sets the level of reimbursement for nurse-provided service at a fixed, less-than-100% percentage of the benefit which would be paid for participant-doctor-provided services, if any, or other doctor-provided services, if the contractor has no participant doctors. An example of a permissible provision would be one which was based on some percentage of the usual, customary, and reasonable (UCR) fee charged by the particular provider of health care service, and which applied the same percentage to the UCR fees of medical doctors and registered nurses alike. The latter provision would be permissible even if it resulted in lower actual dollar amounts for benefits for nurse-provided services than for doctor-provided services, since the difference would result from the disparity of fees actually charged by medical doctors and registered nurses rather than from an arbitrary formula based on assumptions concerning the relative worth of doctor-provided services versus nurse-provided services. A contract provision is not unilaterally imposed and is permissible, if it sets the benefit level in accord with an agreement between the health care service contractor and the particular registered nurse for whose services the benefits are provided.

(4) To comply with RCW 48.44.290, no health care service contractor agreement may contain a provision which places restrictions or limitations on benefits for nurse-provided health care services which are not also placed on benefits for doctor-provided health care services. An example of an impermissible provision would be one which limited the number of office calls made to a registered nurse to a number less than the limit for office calls made to a medical doctor. A contract provision which places such a limitation or restriction on benefits for nurse-provided health care services will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020(2)(f). [Statutory Authority: RCW 48.44.050.

82-02-004 (Order R 81-8), § 284-44-045, filed 12/28/81.]

WAC 284-44-060 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-44-100 Authority and purpose. This regulation, WAC 284-44-100 through 284-44-220, is promulgated under the authority of RCW 48.44.050. Its purpose is to

(1) Provide guidelines for the implementation of RCW 48.44.040 and 48.44.020(2)(d) as to the filing of contract forms and rate schedules, and

(2) Establish standards for the reasonableness of anticipated loss ratios to implement the authority of the commissioner to disapprove contract forms where the benefits provided are unreasonable in relation to the amount charged. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-100, filed 7/21/81, effective 10/1/81.]

WAC 284-44-110 Applicability and scope. This regulation applies to all health care service contractors registered in this state under chapter 48.44 RCW. It applies to every contract, rider and endorsement form and every rate schedule, and any modification or change thereof, which is required to be filed with the commissioner pursuant to RCW 48.44.040 and 48.44.020(2). It does not apply to health maintenance organizations registered in this state under chapter 48.46 RCW. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-110, filed 7/21/81, effective 10/1/81.]

WAC 284-44-120 Definitions. For the purpose of this regulation the following terms shall have the meaning stated herein:

(1) "Amount charged" shall mean all sums charged, received, or deposited as consideration for a "contract" or "group contract" or the continuance thereof. An assessment or a membership, contract, survey, inspection, service or similar fee or charge made by the health care service contractor in consideration for a "contract" or "group contract" is deemed part of the "amount charged."

(2) "Certificate" shall mean the statement of coverage document furnished subscribers covered under a "group contract."

(3) "Claim" shall mean the cost of health care services paid to or provided on behalf of a "subscriber" in accordance with the terms of a "contract" or "group contract."

(4) "Contract" shall mean an agreement to provide health care services or pay health care costs for or on behalf of an individual "subscriber" and such eligible dependents as may be included therein.

(5) "Contract form" shall mean the prototype of a "contract" or "group contract" filed with the commissioner by a health care service contractor.

(6) "Earned amount charged" shall mean the "amounts charged" applicable to an accounting period whether received before, during or after such period.

(7) "Expenses" shall mean and include, but not be limited to the following:

- (a) Claims processing costs
- (b) Home office and field overhead
- (c) Acquisition and selling costs
- (d) Taxes
- (e) Contribution to surplus
- (f) All other costs except "claim" payments to or on behalf of the "subscriber."

(8) "Franchise plan" shall have the meaning set forth in RCW 48.20.350.

(9) "Group contract" shall mean an agreement issued to an employer, corporation, labor union, association, trust or other organization to provide health care services to employees or members of such entities and/or the dependents of such employees or members.

(10) "Incurred claims" shall mean:

- (a) "Claims" paid during the accounting period, plus
- (b) the changes in reserves for "claims" which have been reported but not paid; plus
- (c) the change in reserves for "claims" which have not been reported but which may reasonably be expected.

(11) "Loss ratio" shall mean the "incurred claims" stated as a percentage of the "earned amount charged."

(12) "Rate schedule" shall mean the schedule of prices for various units of coverage which are used to calculate the "amount charged."

(13) "Subscriber" shall mean a person on whose behalf a "contract" or "certificate" is issued. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-120, filed 7/21/81, effective 10/1/81.]

WAC 284-44-130 When filing is required. (1) Pursuant to RCW 48.44.040 and 48.44.020(2)(d), every contract, rider or endorsement form and any modifications thereof, and every rate schedule and any change thereof shall be filed with the commissioner

- (a) before being offered for sale to the public,
- (b) before such forms are modified or rate schedules are changed, and
- (c) within thirty days after the end of a three-year period during which a previous filing has remained unchanged for such period, including filings made prior to the effective date of this regulation.

(2) Filings of negotiated contract, rider and endorsement forms, and rate schedules applicable thereto, which are placed into effect at time of negotiation or which have a retroactive effective date shall not be required to be filed in accordance with (1)(a), (b) and (c) of this section but shall be filed within thirty working days after group contract negotiations have been completed. An explanation for the delayed filing shall be given on the filing document set forth in WAC 284-44-220.

(3) If a return copy of the filing is desired it shall be submitted in duplicate. The duplicate copy will be stamped by the commissioner to indicate receipt of the filing and will be returned to the sender if a return self addressed envelope is enclosed with the filing. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-130, filed 7/21/81, effective 10/1/81.]

WAC 284-44-140 General contents of all filings. Each filing required to be made pursuant to WAC 284-44-130 shall include:

(1) The information required on the filing documents set forth in WAC 284-44-210 for nonnegotiated forms and rate schedules or as set forth in WAC 284-44-220 for negotiated forms and rate schedules,

(2) The anticipated loss ratio over the lesser of three years or the period for which the underlying assumptions are expected to remain reasonable,

(3) With respect to revisions of a previously filed contract, rider or endorsement form, the magnitude of any change in the amount charged during the latest three rate periods or the latest three contract years, whichever is greater, and

(4) Certification by an actuary, a corporate officer or other qualified designated individual that the filing is in compliance with the applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-140, filed 7/21/81, effective 10/1/81.]

WAC 284-44-150 Experience records. (1) Every health care service contractor shall maintain for each contract, rider or endorsement form for each rating period or contract year records of:

- (a) Incurred claims,
- (b) earned amounts charged,
- (c) expenses, and
- (d) contributions to the corporate reserve account.

(2) Such records shall include data for rider and endorsement forms which are used with the contract forms. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under contract forms which provide substantially similar coverage may be combined for record keeping purposes. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-150, filed 7/21/81, effective 10/1/81.]

WAC 284-44-160 Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, including:

(1) Statistical credibility of amounts charged and services and benefits paid, such as low exposure, low loss frequency and recoupment;

(2) Experienced and projected trends relative to changes in medical costs and changes in utilization;

(3) The concentration of experience at early contract durations where selection or adverse-selection in morbidity are applicable and where loss ratios are expected to be substantially different at later durations;

(4) The mix of business by risk classification; and

(5) Adverse selection or lapse factors reasonably expected in connection with revisions to contract provisions, services and benefits and amounts charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-160, filed 7/21/81, effective 10/1/81.]

WAC 284-44-170 Minimum required anticipated loss ratio. (1) Benefits shall be deemed reasonable in relation to amount charged provided the anticipated loss ratio is at least

- (a) 65% for individual subscriber contract forms,
- (b) 70% for "franchise plan" contract forms, and
- (c) 80% for group contract forms.

(2) With the approval of the commissioner contract, rider and endorsement forms which provide substantially similar coverage may be combined for the purpose of determining the anticipated loss ratio. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-170, filed 7/21/81, effective 10/1/81.]

WAC 284-44-180 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-44-190 Unique contract forms. The requirements of WAC 284-44-140 and of 284-44-170 may be waived or modified upon a finding by the commissioner that a contract, rider or endorsement form contains or involves unique provisions or circumstances such as:

- (1) Negotiated, experience rated or merit rated contract, rider or endorsement forms;
- (2) Group contract forms designed to cover 25 or fewer subscribers or group contract forms which are designed to generate an unusually small amount charged per subscriber;
- (3) Unusual employment, geographic, or other circumstances of the subscribers entailing high acquisition costs or other unusual expenses;
- (4) A high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;
- (5) Unusual product features such as long elimination periods, high deductibles and high maximum limits or
- (6) Issuance on a basis where the benefits provided and amount charged are determined by an affiliated health care service contractor outside of this state as to which the health care service contractor does not have direct control of the services and benefits offered and the amount charged for such contract form. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-190, filed 7/21/81, effective 10/1/81.]

WAC 284-44-200 Effective date. This regulation, WAC 284-44-100 through 284-44-220, shall become effective on October 1, 1981. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-200, filed 7/21/81, effective 10/1/81.]

WAC 284-44-210 "Filing document" form-- Standard contract filing information.

[CODIFICATION NOTE: The graphic presentation of this table has been varied slightly in order that it would fall within the printing specifications for the Washington Administrative Code.]

STANDARD CONTRACT FILING INFORMATION

(Health Care Contractor):

Contract Form Number

Effective Date Date Submitted

... Individual Contract

... Medicare Supplement Contract

... Community Rated Contract

... Conversion Contract

... New Contract (attach contract)

... No Change in Contract Past 3 years

If this is a Revision of an Existing Contract, check here (...) and attach appropriate endorsements/riders.

a) ... Experience Rate Change ... %

b) ... Recoupment ... %

c) ... Benefit Change(s) ... %

d) ... Reserves ... %

Current Rates
Experience Rate Change
Recoupment
Reserves
Benefit Change(s)
Total New Rates

EXPERIENCE (Provide information for the latest three rate periods or latest three contract years, whichever is greater.)

	Current Rate Period	First Prior Rate Period	Second Prior Rate Period
Rate Period			
Experi- ence	From ... to ...	From ... to ...	From ... to ...
Earned Income			
Paid Claims			
Beginning Incurred Reserve			
Ending Incurred Reserve			
Incurred Claims			
Loss Ratio Percentage			
Expenses			
Gain/Loss			

Contribution to Corporate Surplus

NONSTANDARD CONTRACT FILING INFORMATION

GENERAL INFORMATION:

- 1. % of premium is charged for administering this contract.
2. a)% is the overall annual trend factor used to project the new rates.
b) Annual trend factor by line of service:

Hospital% Professionals% Dental% Other:%

3. Rate Period Claim Breakdown:

Table with 7 columns: Hospital, Professionals, Dental, Other. Rows for percentage and dollar amounts.

- 4. months experience was used to develop the new rates.
From to

- 5. For what period are the new rates anticipated to remain in effect?
From to

- 6. The anticipated loss ratio over the period the new rates are assumed to remain adequate is%.

- 7. List the effective date and increase percentage of all rate changes in the past three rate periods.

1) 2) 3)
(date) % (date) % (date) %

- 8. Comments or additional information

- 9. I hereby certify that this filing is in compliance with applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

Signed

[Statutory Authority: RCW 48.44.050, 81-15-070 (Order R 81-3), § 284-44-210, filed 7/21/81, effective 10/1/81.]

WAC 284-44-220 "Filing document" form--Non-standard contract filing information.

[CODIFICATION NOTE: The graphic presentation of this table has been varied slightly in order that it would fall within the printing specifications for the Washington Administrative Code.]

- (Health Care Contractor):
(Contract Holder):
Effective Date of Contract
Effective Date (of change) Date Submitted
Contract Form Number Contract Number
... New contract (attach contract)
... Revision of Existing Contract (attach appropriate endorsements/riders)
a) ... Experience Rate Change ... %
b) ... Recoupment ... %
c) ... Benefit Change(s) ... %
d) ... Reserves ... %

- Current Rates
Experience Rate Change
Recoupment
Reserves
Benefit Change(s)
Total New Rates

EXPERIENCE (Provide information for the latest three rate periods or latest three contract years, whichever is greater.)

Table with 4 columns: Rate Period, Experience, From ... to ..., and various metrics like Earned Income, Paid Claims, Reserve, etc.

Comments or additional information:

.....
.....
.....
.....

I hereby certify that this filing is in compliance with applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

Signed

Title

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-220, filed 7/21/81, effective 10/1/81.]

WAC 284-44-250 Accounting method. Beginning January 1, 1983, to aid in the administration of chapter 48.44 RCW, every health care service contractor shall account for its business on the accrual basis, and any annual financial statement filed after December 31, 1983, pursuant to RCW 48.44.095, shall be reported on such accrual basis. [Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-250, filed 11/5/82, effective 1/1/83.]

WAC 284-44-300 Purpose and applicability. (1) The purpose of this regulation, WAC 284-44-300 through 284-44-360, is to establish indemnity requirement rules and procedures for the effectuation of RCW 48.44.030 and to aid in the administration thereof.

(2) This regulation applies to every health care service contractor registered pursuant to chapter 48.44 RCW. [Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-300, filed 11/5/82, effective 1/1/83.]

WAC 284-44-310 Agreement underwritten by insurance. (1) If, pursuant to RCW 48.44.030, the agreement is underwritten by a contract or policy of insurance, such contract or policy shall:

- (a) Have a continuous term;
- (b) Fully insure the benefits of the persons who have paid for or contracted for covered health care services, which persons shall be designated as beneficiaries, when such services are not performed by the health care service contractor or a participant;
- (c) Contain a provision that, in the event of cancellation, the coverage shall continue with respect to services provided prior to the effective date of such cancellation;
- (d) Contain a provision that it may not be cancelled without ninety days advance written notice to the insured or insurer by the cancelling party; and
- (e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner,

health care services division, by the insurer of any cancellation.

(2) The original or a true copy of the actual insurance contract or policy shall be filed with the insurance commissioner, health care services division, prior to its effective date. [Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-310, filed 11/5/82, effective 1/1/83.]

WAC 284-44-320 Agreement guaranteed by a surety company. (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a surety company, such agreement shall:

- (a) Be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340;
- (b) Contain a provision that the bond will be for the benefit of the persons who have paid for or contracted for the health care services;
- (c) Contain a provision that in the event of cancellation, the bond will continue to cover liabilities for services provided prior to the effective date of such cancellation;
- (d) Contain a provision that it may not be cancelled or terminated without ninety days advance written notice to the assured or surety company by the cancelling party;
- (e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the surety company of any cancellation of such surety agreement.

(2) The original or a true copy of the actual surety bond shall be filed with the insurance commissioner, health care services division, prior to its effective date. [Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-320, filed 11/5/82, effective 1/1/83.]

WAC 284-44-330 Agreement guaranteed by a deposit of cash or securities. (1) If, pursuant to RCW 48.44.030, the agreement is guaranteed by a deposit of cash or securities, such deposit shall be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340.

(2) Securities eligible for such deposit shall be those set forth in RCW 48.13.040, 48.13.050, 48.13.080, 48.13.100, 48.13.200, and 48.13.220. The commissioner may, upon advance approval, allow other securities to be included as deposits pursuant to RCW 48.13.250.

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value shall be the measurement. [Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-330, filed 11/5/82, effective 1/1/83.]

WAC 284-44-340 Modification of amount of reimbursement or indemnity. (1) Reduced deposit requirements may be permitted when data satisfactory to the commissioner are provided which indicate an amount less than that set forth in WAC 284-44-320 and 284-44-330 is adequate to cover incurred but unpaid reimbursement or indemnity benefits. In determining a lesser requirement, the commissioner will include in his consideration:

(a) The overall adequacy of the contractor's reserves for future benefits;

(b) The relationship between indemnity claims and claims covered by contractual agreements with providers;

(c) The overall financial stability of the contractor; and

(d) A reasonable projection of any increase or decrease of such benefits.

(2) The commissioner may from time to time require additional indemnification to be furnished when a review of the health care service contractor's affairs demonstrates that existing indemnification is inadequate. [Statutory Authority: RCW 48.44.050, 82-23-010 (Order R 82-6), § 284-44-340, filed 11/5/82, effective 1/1/83.]

WAC 284-44-350 Records and reporting. (1) Each health care service contractor shall maintain records which separately reflect the amount of service benefits and the amount of reimbursement or indemnity benefits. Reasonable approximation based on paid claims data may be used to project incurred indemnity benefits. Such amounts shall be reported to the commissioner on forms prescribed by the commissioner and shall be filed with the annual statement and at such other times as the commissioner may require. The report shall be accompanied by an inventory and valuation of any securities which are used to satisfy the depository requirement. If the amount of the guarantee is not sufficient to satisfy the requirements, an appropriate additional amount shall be obtained, and shall be deposited with, or evidenced to, the commissioner within thirty days of the filing of the report.

(2) A health care service contractor using either a policy of insurance or a surety bond to provide for indemnification shall notify the insurance commissioner, health care services division, sixty days in advance of termination or cancellation of the contract or policy of insurance or surety bond. [Statutory Authority: RCW 48.44.050, 82-23-010 (Order R 82-6), § 284-44-350, filed 11/5/82, effective 1/1/83.]

WAC 284-44-360 Effective date. (1) This regulation, WAC 284-44-300 through 284-44-360, and 284-44-250 shall take effect January 1, 1983.

(2) If any health care service contractor holding a valid certificate of registration in this state immediately prior to the effective date of this rule is unable to meet the requirements of WAC 284-44-300 through 284-44-350, the commissioner may, upon its request, allow it to continue to transact business for such period of time and

under such conditions as he deems appropriate. [Statutory Authority: RCW 48.44.050, 82-23-010 (Order R 82-6), § 284-44-360, filed 11/5/82, effective 1/1/83.]

Chapter 284-50 WAC WASHINGTON DISABILITY INSURANCE ADVERTISING REGULATIONS

WAC	
284-50-305	Applicability and scope.
284-50-320	Prohibited policy provisions.
284-50-380	Outline of coverage requirements for individual coverages.
284-50-450	Repealed.
284-50-455	Repealed.
284-50-460	Repealed.
284-50-465	Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-50-450	Purpose and authority. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-450, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
284-50-455	Information to be furnished, style. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-455, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
284-50-460	Form to be used. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-08-024 (Order R 78-2), § 284-50-460, filed 7/12/78; 78-05-039 (Order R-78-1), § 284-50-460, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
284-50-465	Effective date. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 78-05-039 (Order R-78-1), § 284-50-465, filed 4/20/78, effective 8/1/78.] Repealed by 82-01-017 (Order R 81-7), filed 12/9/81. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.

WAC 284-50-305 Applicability and scope. This regulation shall apply to all individual disability insurance policies delivered or issued for delivery in this state on and after the effective date hereof, except it shall not apply to individual policies issued pursuant to a conversion privilege under a policy of group or individual insurance when such group or individual policy includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted. This regulation shall not apply to medicare supplement insurance policies, as such policies are defined in The Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-305, filed 12/9/81; Order R-76-4, § 284-50-305, filed 10/29/76, effective 3/1/77.]

WAC 284-50-320 Prohibited policy provisions. (1) Except as provided in WAC 284-50-315(5), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproduction organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than 6 months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder, and the premium for such optional insurance shall be clearly and separately stated in the premium notice.

(3) No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for such insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and such preexisting condition is not specifically excluded by the terms of the policy.

(4) No policy shall provide a return of premium benefit except as permitted by this rule. For purposes of this rule, a return of premium benefit refers only to that benefit which is equal to a stated portion of the premiums paid for the benefit and the basic coverage decreased by claims paid to the insured under the basic coverage. A disability income policy may contain a return of premium benefit if it meets the following conditions:

(a) Such return of premium benefit shall not be reduced by an amount greater than the aggregate of any claims paid under the policy; and

(b) Such benefit shall be provided by rider or the insurer shall provide a similar policy without such benefit to which the insured may convert; and

(c) The premiums for the disability income and return of premium benefits shall be shown separately on the schedule page of the policy; and

(d) The policy shall guarantee that it is renewable; and

(e) Submission of the benefit form for approval shall be accompanied by a demonstration that the premium and reserve structure is such that adverse deviations from the assumptions thereunder are minimized; and

(f) The insurer provides the commissioner with its assurance that it will promptly notify the insured at such time as the return of premium benefit is not payable to

the insured because of the aggregate of claims paid under the policy, together with instructions as to the insured's right and manner of converting to the similar policy or to cancel the rider.

(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except with respect to the following:

(a) Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

(b) Mental or emotional disorders, alcoholism and drug addiction;

(c) Pregnancy, except for complications of pregnancy, other than for policies defined in WAC 284-50-355;

(d) Illness, treatment or medical condition arising out of:

(i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(ii) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(iii) Aviation;

(iv) With respect to short-term nonrenewable policies, interscholastic sports;

(e) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

(f) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain;

(g) Treatment (except emergency treatment for which legal liability exists to the insured for the costs thereof) provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(h) Dental care or treatment;

(i) Eye glasses, hearing aids and examination for the prescription or fitting thereof;

(j) Rest cures, custodial care, transportation and routine physical examinations;

(k) Territorial limitations;

(l) Specified disease and specified accident policies issued in accord with WAC 284-50-365.

(7) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described

preexisting diseases, physical condition or extra-hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, and use of endorsements is governed by RCW 48.20.015.

(8) Except as otherwise provided in WAC 284-50-330(2) and 284-50-380(5), the terms "Medicare supplement," "Medigap" and words of similar import shall not be used unless the policy is issued in compliance with The Medicare Supplemental Health Insurance Act, chapter 153, Laws of 1981, and chapter 284-55 WAC.

(9) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RCW 48.18.110. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-320, filed 12/9/81; Order R-76-4, § 284-50-320, filed 10/29/76, effective 3/1/77.]

WAC 284-50-380 Outline of coverage requirements for individual coverages. (1) No individual disability insurance policy subject to this regulation shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in WAC 284-50-385 through 284-50-425 is completed as to such policy and:

(a) Is either delivered with the policy; or
 (b) Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

(2) If an outline of coverage was delivered at the time of application and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy must accompany the policy when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is *not* identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued." In addition, the insurer shall comply with the provisions set forth in RCW 48.20.015.

(3) The appropriate outline of coverage for policies providing hospital coverage which only meets the standards of WAC 284-50-335 shall be that statement contained in WAC 284-50-385. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-340 shall be the statement contained in WAC 284-50-395. The appropriate outline of coverage for policies providing coverage which meets the standards of both WAC 284-50-335 and 284-50-350 or WAC 284-50-340 and 284-50-350 or WAC 284-50-335, 284-50-340, and 284-50-350 shall be the statement contained in WAC 284-50-405.

(4) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(5) Outlines of coverage delivered in connection with policies defined in this regulation as Hospital confinement indemnity (WAC 284-50-345), Specified disease (WAC 284-50-365), or Limited benefit health insurance coverages (WAC 284-50-370) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of WAC 284-50-400, 284-50-420 and 284-50-425, the following language which shall be printed or stamped on or attached to the first page of the outline of coverage: "THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company." Such notice shall be in no less than twelve point type. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-50-380, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-380, filed 12/9/81; Order R-76-4, § 284-50-380, filed 10/29/76, effective 3/1/77.]

WAC 284-50-450 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-50-455 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-50-460 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-50-465 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-51 WAC

STANDARDS FOR COORDINATION OF BENEFITS

WAC

284-51-010	Purpose and scope.
284-51-020	Required provisions for coordination of benefits.
284-51-030	Benefits subject to coordination.
284-51-040	"Plan" defined.
284-51-050	Allowable expense.
284-51-060	Claim determination period.
284-51-070	Order of benefit determination.
284-51-080	Determination of length of coverage.
284-51-090	Coordination procedures.
284-51-100	Time limit.
284-51-110	Small claim waivers.
284-51-120	Facility of payment.
284-51-130	Right of recovery.
284-51-140	Right to receive and release necessary information.
284-51-150	Disclosure of coordination.
284-51-160	Conformity of contracts.
284-51-170	Effective date.
284-51-180	Appendix A, form for "effect on benefits" provision.

WAC 284-51-010 Purpose and scope. (1) This regulation, WAC 284-51-010 through 284-51-180, is adopted pursuant to RCW 48.21.200 to establish standard coordination of benefit provisions, and uniform guidelines for their interpretation and administration, for group disability insurance policies (as defined in RCW 48.21.010), health care service contractor group agreements and health maintenance organization group

agreements (all of which are hereinafter referred to as "group contracts"), whose hospital, medical, or surgical benefits may be reduced because of other existing coverages. This regulation applies to group contracts delivered or issued for delivery in Washington state. Except where the context otherwise requires, the definitions given in the Washington Insurance Code, Title 48 RCW, govern the construction of this regulation.

(2) This regulation does not require the use of coordination of benefit provisions in group contracts, however, if a group contract contains any provision for the reduction of benefits otherwise payable because of other insurance, it shall be consistent with and no less favorable than the requirements of this regulation, except that a plan of coverage designed to be supplementary over the policyholder's underlying basic plan of coverage may provide that its coverage shall be excess to that specific policyholder's plan of basic coverage from whatever source provided.

(3) For purposes of this regulation, the word "insurer" includes health care service contractors and health maintenance organizations.

(4) Pursuant to RCW 48.21.200(1) and WAC 284-44-040(9), no group disability insurance policy which provides benefits for hospital, medical or surgical expenses and no group health care service contract may contain any provision permitting a reduction or refusal to pay benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under any individual disability insurance policy (including "franchise plan" insurance) or any individual health care service contract.

(5) For purposes of this regulation, the words "medical benefits" shall be broadly construed and shall include, but not be limited to dental, optical, prescription drug and audio benefits. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-010, filed 6/18/81, effective 1/1/82.]

WAC 284-51-020 Required provisions for coordination of benefits. (1) A group contract which provides for coordination of hospital, medical, or surgical benefits shall contain the required contractual provisions set forth in WAC 284-51-030 through 284-51-140, and 284-51-180, or provisions which are not less favorable to the insured or the insured's beneficiary. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or sub-captions as the commissioner may approve. Such provisions collectively constitute the "coordination of benefits provision," which is referred to therein as "this provision."

(2) A blanket disability insurance policy, as defined in RCW 48.21.040, is not within the scope of this regulation, thus it may include an "excess" or "nonduplication of benefits" provision. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-020, filed 6/18/81, effective 1/1/82.]

WAC 284-51-030 Benefits subject to coordination.

(1) A group contract which provides for coordination of all benefits thereunder shall contain a provision as follows: "BENEFITS SUBJECT TO THIS PROVISION: All of the benefits provided under this policy are subject to this provision."

(2) If one or more of the policy benefits are to be exempt from reduction under the coordination provision, appropriate changes shall be made in the wording set forth in subsection (1). For example: "Only the Major Medical Expense Benefits provided under this policy are subject to this provision." [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-030, filed 6/18/81, effective 1/1/82.]

WAC 284-51-040 "Plan" defined. (1) A group contract which provides for coordination of benefits shall contain a provision stating what benefits from that policy and other sources are to be recognized under the coordination provision. Each such source shall be defined as a "plan."

(2) The definition of a "plan" may include such sources of benefits or services as:

(a) Group or blanket disability insurance policies and health care service contractor and health maintenance organization group agreements, issued by insurers, health care service contractors and health maintenance organizations;

(b) Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans;

(c) Governmental programs; and

(d) Coverage required or provided by any statute.

(3) This provision shall include the following wording or its equivalent: "The term 'plan' shall be construed separately with respect to each policy, agreement or other arrangement for benefits or services, and separately with respect to the respective portions of any such policy, agreement or other arrangement which do and which do not reserve the right to take the benefits or services of other policies, agreements or other arrangements into consideration in determining its benefits."

(4) If not all of the group contract's benefits are subject to coordination, this provision shall include the following wording or its equivalent: "'This plan' means that portion of this policy which provides the benefits that are subject to this provision." Any benefits provided under the group contract that are not subject to this provision constitute another plan.

(5) The definition of a "plan" may not include individual or family disability insurance policies permitted by chapter 48.20 RCW; nongroup health care service contractor agreements permitted under chapter 48.44 RCW; nongroup health maintenance organization agreements permitted under chapter 48.46 RCW.

(6) The definition of a "plan" may not include group hospital indemnity benefits (that is, benefits paid on other than an expense incurred basis) of \$200 per day or less. It may, however, include reimbursement-type benefits where the insured has the right to elect indemnity-

type benefits in lieu of the reimbursement benefits at the time of claim. The amount of group hospital indemnity benefits which exceeds \$200 per day may be included in the definition of "plan."

(7) The definition of a "plan" may not include coverage on pre-school, grammar school, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or a "to and from school" basis.

(8) The definition of a "plan" may include automobile insurance policies required by statute to provide medical benefits. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-040, filed 6/18/81, effective 1/1/82.]

WAC 284-51-050 Allowable expense. (1) A group contract which provides for coordination of benefits shall contain a provision stating what expenses are to be recognized under the coordination provision, as follows: "ALLOWABLE EXPENSE: 'Allowable Expense' means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered as both an Allowable Expense and a benefit paid."

(2) The inclusion of Medicare or similar governmental benefits in the definition of a plan will not require the definition of allowable expense to recognize governmental benefits other than hospital, medical and surgical benefits. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-050, filed 6/18/81, effective 1/1/82.]

WAC 284-51-060 Claim determination period. A group contract which provides for coordination of benefits shall contain a provision stating the period to be used in applying the coordination provision, as follows: "CLAIM DETERMINATION PERIOD: 'Claim Determination Period' means calendar year." [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-060, filed 6/18/81, effective 1/1/82.]

WAC 284-51-070 Order of benefit determination. (1) When a claim under a plan with a coordination of benefits provision involves another plan which also has a coordination of benefits provision, the following rules will be applied by the insurers involved to decide the order in which the benefits payable under the respective plans will be determined:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent. However, to the extent the benefits of a plan which covers the person are provided by a plan for retired persons, such plan may provide that its benefits shall be determined after any other plan covering such person, in which case such provision shall be controlling.

(b) The benefits of a plan which covers the person on whose expense claim is based as a dependent of a male person shall be determined before the benefits of a plan which covers such person as a dependent of a female person, except that in the case of a person for whom claim is made as a dependent child,

(i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

(ii) when parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; or

(iii) notwithstanding items (i) and (ii), if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

(2) If the policy provides more than one benefit, the policy shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the policy. Suggested language for such provision is included in Appendix A, WAC 284-51-180.

(3) A group contract which provides for coordination of benefits shall contain a provision entitled "Effect on benefits," stating the manner in which benefits are reduced by coordination, which provision shall be substantially as set forth in Appendix A, WAC 284-51-180. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-070, filed 6/18/81, effective 1/1/82.]

WAC 284-51-080 Determination of length of coverage. For the purpose of determining length of coverage under WAC 284-51-070(1)(c), the following rules shall apply:

(1) In determining the length of time a person in a given group has been covered under a given plan, two successive plans covering the group shall be considered one continuous plan if the person was eligible for the coverage under the second plan within 24 hours after the first plan terminated. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to

another does not of itself constitute the start of a new plan for purposes of WAC 284-51-070(1)(c).

(2) If a person's effective date of coverage under a plan is subsequent to the date the carrier first contracted to provide the plan for the group concerned, the carrier shall assume for purposes of WAC 284-51-070(1)(c), in the absence of specific information to the contrary, that the person's length of time covered under the plan is measured from his effective date of coverage. If a person's effective date of coverage under a plan is the same as the date the carrier first contracted to provide the plan for the group concerned, the carrier shall request the group to furnish the date the person first became covered under the earliest of any prior plans the group may have had. If such date is not furnished, the date the person first became a member of the group shall be used as the date from which to determine the length of time his coverage under the plan has been in force. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-080, filed 6/18/81, effective 1/1/82.]

WAC 284-51-090 Coordination procedures. Insurers shall use the following claims administration procedures to expedite the claim payments where coordination of benefits is involved:

(1) There shall be continuing education of claim personnel. Accurate and prompt completion of such forms as the health insurance council's duplicate coverage inquiry form (DUP-1) by the inquiring carrier and the responding carrier should be stressed. This education effort should also be encouraged through local claim associations.

(2) Claim personnel shall make every reasonable effort, including use of the telephone, to speed up exchange of coordination of benefits information.

(3) Insurers shall consider building a local data file with at least basic information on group health plans for major employers in the local area. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-090, filed 6/18/81, effective 1/1/82.]

WAC 284-51-100 Time limit. No insurer shall unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. Each insurer shall establish a time limit after which payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage shall be conducted concurrently, so as to create no further delay in the ultimate payment of benefits. If an insurer is required by the time limit to make payment as the primary plan because it then has insufficient information to make it a secondary plan, it may exercise its rights under its "Right of Recovery" provision to recover any excess payments made thereby. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-100, filed 6/18/81, effective 1/1/82.]

WAC 284-51-110 Small claim waivers. In appropriate cases, insurers are encouraged to waive the investigation of possible other plan coverage on claims less than \$50, but if additional liability is incurred which raises the claim above \$50, the entire liability may be included in the coordination of benefits computation. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-110, filed 6/18/81, effective 1/1/82.]

WAC 284-51-120 Facility of payment. A group contract which provides for coordination of benefits shall contain a provision substantially as follows: FACILITY OF PAYMENT: Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over to any Plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be considered benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this Plan." [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-120, filed 6/18/81, effective 1/1/82.]

WAC 284-51-130 Right of recovery. A group contract which provides for coordination of benefits shall contain a provision substantially as follows: RIGHT OF RECOVERY: Whenever payments have been made by the insurer with respect to Allowable Expenses in total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the insurer shall determine: any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any other organizations or other Plans." [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-130, filed 6/18/81, effective 1/1/82.]

WAC 284-51-140 Right to receive and release necessary information. A group contract which provides for coordination of benefits may contain a provision substantially as follows: "RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing this provision and any provision of similar purpose in any other Plan, the insurer may, with such consent of the insured person as may be necessary, release to or obtain from any other insurer, organization or person any information, with respect to any person, which the insurer considers necessary for such purpose. Any person claiming benefits under this Plan shall furnish to the insurer the information necessary for such purpose." [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-140, filed 6/18/81, effective 1/1/82.]

WAC 284-51-150 Disclosure of coordination. (1) Each certificate of coverage under a group contract which provides for coordination of benefits must contain, at least in summary form, a description of the coordination provision.

(2) Each certificate of coverage shall contain a statement substantially as follows: "If you have other coverage besides ours, we recommend that you submit your claim to us and to each other insurer at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid."

(3) In addition, each insurer shall urge its group clients to take reasonable steps so that those insured by the group policy are exposed to reasonably concise explanations, with as little technical terminology as is consistent with accuracy, of the purpose and operation of the coordination of benefits provision. Such educational effort may, for example, take the form of articles in company magazines or newspapers, speeches before labor organizations or other employee groups, brochures in pay envelopes, notices on bulletin boards and materials used by employers in counseling employees. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-150, filed 6/18/81, effective 1/1/82.]

WAC 284-51-160 Conformity of contracts. The prohibition of coordination provisions' reducing total benefits below 100 percent of allowable expenses became effective for group contracts as of September 8, 1975, pursuant to RCW 48.21.200. Any group contract in effect as of the effective date of this regulation, including any group contract containing an "excess" or "nonduplication" provision, which is not in compliance with this regulation, shall be brought into compliance no later than on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-160, filed 6/18/81, effective 1/1/82.]

WAC 284-51-170 Effective date. This regulation, WAC 284-51-010 through 284-51-180, shall take effect January 1, 1982. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-170, filed 6/18/81, effective 1/1/82.]

WAC 284-51-180 Appendix A, form for "effect on benefits" provision. Effect on benefits: (1) This provision shall apply in determining the benefits for a person covered under this plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

(a) The benefits that would be payable under this plan in the absence of this provision, and

(b) The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

(2) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other plans, except as provided in item (3) of this section, shall not exceed the total of such allowable expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) another plan which is involved in item (2) of this section and which contains a provision coordinating its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(b) the rules set forth in item (4) of this section would require this plan to determine its benefits before such other plan then the benefits of such other plan will be ignored for the purposes of determining the benefits under this plan.

(4) For the purpose of item (3) of this section, the rules establishing the order of benefit determination are:

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent. However, if a plan is one providing benefits for retired persons and it provides that its benefits shall be determined after any other plan covering a retired person, such provision shall be controlling.

(b) The benefits of a plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a plan which covers such person as a dependent of a female person, except that in the case of a person for whom claim is made as a dependent child.

(i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; and

(ii) when the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding items (i) and (ii) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before

the benefits of any other plan which covers the child as a dependent child.

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

(5) (Note: This item (5) may be omitted if the plan provides only one benefit. If the contract provides more than one benefit, it shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the contract. The following wording is illustrative of a policy in which all benefits are affected.)

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan. [Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-180, filed 6/18/81, effective 1/1/82.]

Chapter 284-55 WAC

MEDICARE SUPPLEMENTAL HEALTH INSURANCE REGULATION

WAC

284-55-010	Purpose.
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WAC 284-55-010 Purpose. The purpose of this regulation is to effectuate the provisions of RCW 48.20.450, 48.20.460 and 48.20.470, and to supplement the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act, by establishing minimum standards for benefits and specific standards for Medicare supplement insurance, by prescribing the "outline of coverage" to be used in the sale of Medicare supplemental insurance, by establishing other disclosure requirements, by prohibiting the use of certain provisions in Medicare supplement insurance policies, by defining and prohibiting certain practices as unfair acts and practices, and establishing loss ratio requirements. [Statutory Authority: RCW 48.66.100, 48.20.470 and

1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-010, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-010, filed 12/9/81.]

WAC 284-55-020 Applicability and scope. (1) Except as otherwise specifically provided, this regulation shall apply to every group and individual policy of disability insurance and to every subscriber contract of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, which relates its benefits to Medicare, or which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. Such policy or contract is referred to in this regulation as "Medicare supplemental insurance" or "Medicare supplement insurance policy."

(2) This regulation shall not apply to:

(a) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(b) A policy or contract of any professional, trade, or occupational association for its members or former members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or have been actively engaged in the same profession, trade or occupation;

(ii) Has been maintained in good faith for purposes other than obtaining insurance; and

(iii) Has been in existence for at least two years prior to the date of initial offering of such policy or plan to its members;

(c) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation;

(d) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation, or

(e) Health maintenance organization contracts specified in section 16, of chapter 153, Laws of 1981, to the extent they may be in conflict with this regulation. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-020, filed 12/9/81.]

WAC 284-55-030 Definitions. For purposes of this regulation:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement insurance policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(b) In the case of a group Medicare supplement insurance policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group medicare supplement insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Insurer" includes fraternal benefit societies, health care service contractors and health maintenance organizations.

(4) "Direct response insurer" means an insurer who, as to a particular transaction, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-030, filed 12/9/81.]

WAC 284-55-035 Policy definitions and terms. No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless such policy or contract contains definitions or terms which conform to the requirements of this section.

(1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(2) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

(a) A definition of such home or facility shall not be more restrictive than one requiring that it:

- (i) Be operated pursuant to law;
- (ii) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
- (iii) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
- (iv) Provide continuous twenty-four hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
- (v) Maintains a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

- (i) Any home, facility or part thereof used primarily for rest;
- (ii) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(iii) A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(3) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the joint commission on accreditation of hospitals.

(a) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

- (i) Be an institution operated pursuant to law; and
- (ii) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

(iii) Provide twenty-four hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "hospital" may state that such term shall not be inclusive of:

- (i) Convalescent homes, convalescent, rest, or nursing facilities; or
- (ii) Facilities primarily affording custodial, educational, or rehabilitative care; or
- (iii) Facilities for the aged, drug addicts, or alcoholics; or

(iv) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(4) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(5) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person which first manifests itself

after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-035, filed 5/26/82.]

WAC 284-55-040 Prohibited policy provisions. (1) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless such policy or contract meets the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act.

(2) No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment, or medical condition, except as follows:

(a) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(b) Mental or emotional disorders, alcoholism and drug addiction;

(c) Illness, treatment, or medical condition arising out of:

(i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(ii) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury;

(iii) Aviation;

(d) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

(e) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of, or in the vertebral column;

(f) Treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories, or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(g) Dental care or treatment;

(h) Eye glasses, hearing aids, and examination for the prescription or fitting thereof;

(i) Rest cures, custodial care, transportation, and routine physical examinations;

(j) Territorial limitations:

Provided, That Medicare supplement insurance policies may not contain, when issued, limitations or exclusions of the type enumerated in (a), (e), (i) or (j) of this subsection that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

(3) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement insurance policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(4) Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Any provision to the contrary is prohibited.

(5) No Medicare supplement insurance policy shall restrict, exclude or limit benefits for a sickness through use of a probationary, or similar, provision. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-040, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44-.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-040, filed 12/9/81.]

WAC 284-55-045 Minimum benefit standards. Except as permitted by WAC 284-55-040(2), no insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy which does not meet the following minimum benefit standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital reserve days;

(3) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days; and

(4) Coverage of twenty percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of two hundred dollars of such expenses and to a maximum benefit of at least five

thousand dollars per calendar year. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-045, filed 5/26/82.]

WAC 284-55-050 Outline of coverage required. An agent or insurer initiating a sale of an individual or group Medicare supplement insurance policy in this state shall complete and sign a disclosure form, and deliver the completed form to the applicant not later than the time of application for the policy. The disclosure form to be used shall be the "outline of coverage," which is set forth in WAC 284-55-060. Except for direct response insurers, an insurer shall obtain an acknowledgment of receipt of such outline from the applicant. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-050, filed 12/9/81.]

WAC 284-55-060 Form for "Outline of coverage."

(COMPANY NAME)
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE

(1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is,

therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare Supplement Coverage – Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3) (a) (for agents:)

Neither (Insert company's name) nor its agents are connected with Medicare.

(b) (for direct responses:)

(Insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION				
semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but \$		
	61st to 90th day	All but \$		
Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	91st to 150th day	All but \$ a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE . . .				
In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital	First 20 days	100% of costs		
	Additional 80 days	All but \$ a day		

SERVICE	BENEFIT	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
discharge.	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician's services, inpatient and outpatient Medicare services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge (after \$ deductible)		

- (5) (Statement that the policy does or does not cover the following:)
 - (a) Private duty nursing,
 - (b) Skilled nursing home care costs (beyond what is covered by Medicare),
 - (c) Custodial nursing home care costs,
 - (d) Intermediate nursing home care costs,
 - (e) Home health care above number of visits covered by Medicare,
 - (f) Physician charges (above Medicare's reasonable charge),
 - (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),
 - (h) Care received outside of U.S.A.,
 - (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for, or the cost of, eyeglasses or hearing aids.
- (6) (An explanation of such terms as "usual and customary," "reasonable and customary," or words of similar import, if used in the policy; a description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements:)
 - (a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)
 - (b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)
 - (7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.)
 - (8) (The amount of premium for this policy.)

.....
 (Insurer's Name)
 By _____ Date _____

 (Agent's or Officer's Signature)

(Drafting note. The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-060, filed 12/9/81.]

WAC 284-55-065 Required disclosure provisions and buyer's guide. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

(2) Where riders or endorsements are used at the time a policy is issued and separate additional premium is charged therefor, such premium charge shall be set forth in the policy.

(3) Insurers issuing accident and sickness policies, certificates, or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare by reason of age must provide to all applicants a Medicare supplement "buyer's guide."

(4) The "buyer's guide" required to be provided is the pamphlet "Guide to Health Insurance for People with

Medicare," developed jointly by the National Association of Insurance Commissioners and Health Care Financing Administration of the United States Department of Health and Human Services, or any reproduction or official revision of that pamphlet. Specimen copies may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C. The guide is identified as Department of Health and Human Services/Health Care Financing Administration Form Number HCFA-02110.

(5) Delivery of the "buyer's guide" must be made whether or not such policies, certificates, or subscriber contracts are advertised, solicited, or issued as Medicare supplement policies. Except in the case of direct response insurers, delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgement of receipt of the "buyer's guide" must be obtained by the insurer. Direct response insurers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-065, filed 5/26/82.]

WAC 284-55-067 Notice regarding policies or subscriber contracts which are not Medicare supplement policies. Any accident and sickness insurance policy or subscriber contract, other than a Medicare supplement policy; disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in WAC 284-55-020(2)(c) and (d), issued for delivery in this state to persons eligible for Medicare by reason of age, shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. Such notice shall be in no less than twelve point type and shall contain the following language: "THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the company." [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-067, filed 5/26/82.]

WAC 284-55-070 Requirements for application forms, replacement. (1) Application forms shall include a question designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any other health care service contract, health maintenance organization contract, disability insurance policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, the insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall be provided in substantially the form set forth in WAC 284-55-080.

(4) The notice required by subsection (2) of this section for a direct response insurer shall be in substantially the form set forth in WAC 284-55-090.

(5) The application form shall also contain questions as to whether, as of the date of the application, the applicant

(a) has any other health care service contract, health maintenance organization contract, disability insurance policy or certificate in force, and

(b) is eligible for state medical assistance coupons (Medicaid). [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-070, filed 12/9/81.]

WAC 284-55-080 Form for "Replacement notice."

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

Drafting Note. This subsection may be modified if preexisting conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

.....
(Date)

.....
(Applicant's Signature)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-080, filed 12/9/81.]

WAC 284-55-090 Form for "replacement notice" by direct response insurer.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your

present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....
(Company Name)

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-090, filed 12/9/81.]

WAC 284-55-100 Return of certificate for refund, unfair practice. It shall be an unfair act and practice for an insurer to issue a certificate that does not have prominently displayed on its first page a notice stating in substance that the person to whom the certificate is issued shall be permitted to return the certificate within 30 days after its delivery to the purchaser and to have the premium refunded if, after examination of the certificate, the purchaser is not satisfied with it for any reason. If a purchaser does return the certificate, pursuant to such notice, to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no certificate had been issued. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-100, filed 12/9/81.]

WAC 284-55-110 Loss ratio requirements. The provisions of this section shall be used in determining whether the loss ratios required by RCW 48.66.100 are met.

(1) With respect to a health care service contractor, compliance with the provisions of WAC 284-44-100 through 284-44-220 shall be required and those provisions shall be controlling. Commencing with reports for the accounting periods beginning on or after January 1, 1983, the minimum anticipated loss ratio requirements set forth in WAC 284-44-170 shall be applicable to Medicare supplement contracts. Such loss ratio requirements are more stringent than those imposed by RCW 48.66.100, are more appropriate and are necessary for the protection of the public interest.

(2) With respect to a health maintenance organization, the loss ratio shall be deemed to have been met if its "expense costs" are 40% or less of the "premium" charged individual subscribers or 25% or less of the "premium" charged subscribers covered under a group contract, with contracts issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, being treated for this purpose as individual contracts:

Provided, That commencing with reports for the accounting periods beginning on or after January 1, 1983, the loss ratio shall be deemed to have been met only if its "expense costs" are thirty-five percent or less of the "premium" charged individual subscribers or twenty percent or less of the "premium" charged subscribers covered under a group contract, with contracts issued as a result of solicitation of individuals through the mail or mass media advertising, including both print and broadcast advertising, being treated for this purpose as individual contracts. Such loss ratio requirements are more stringent than those imposed by RCW 48.66.100, are more appropriate and are necessary for the protection of the public interest.

(3) With respect to any other insurer, a loss ratio shall be the "incurred claims" stated as a percentage of the "earned premiums."

(4) For purposes of this section, the following definitions shall apply:

(a) "Incurred claims" shall mean:

(i) "Claims" paid during the accounting period, plus

(ii) The changes in reserves for "claims" which have been reported but not paid, plus

(iii) The change in reserves for "claims" which have not been reported but which may reasonably be expected.

(iv) The change in policy reserves as defined for the insurer's statutory annual statement.

(b) "Earned premium" shall mean the "premium" applicable to an accounting period whether received before, during or after such period.

(c) "Claims" shall mean the costs of benefits paid to or provided on behalf of the persons on whose behalf a contract or certificate is issued, not including "expense costs."

(d) "Expenses costs" shall mean:

(i) Claims processing costs,

(ii) Home office and field overhead,

(iii) Acquisition and selling costs,

(iv) Taxes,

(v) Contributions to surplus or profit, and

(vi) All other costs, except benefit payments to or on behalf of the covered persons.

(e) "Premium" shall mean all sums charged, received, or deposited as consideration for a Medicare supplement insurance policy or the continuance thereof. An assessment or a membership, contract, survey, inspection, service or other similar fee or charge made by the insurer in consideration for such contract is deemed part of the "premium." [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R. 82-3), § 284-55-110, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), 284-55-110, filed 12/9/81.]

Chapter 284-58 WAC

REGULATIONS PERTAINING TO FORM FILINGS

WAC

284-58-010 Title and purpose.

[1982 WAC Supp—page 1080]

284-58-020	Scope and general contents.
284-58-030	General contents of all life and disability form and disability rate filings.
284-58-040	Life and disability filing report documents.
284-58-050	Document to be used in filing life and disability forms.
284-58-060	Document to be used in filing disability rates.
284-58-070	General designation of life and disability forms which may not be filed by certification.
284-58-080	Individual disability insurance forms, certification not permitted.
284-58-090	Group disability insurance forms, certification not permitted.
284-58-100	Group disability insurance forms which may be filed by certification.
284-58-110	Blanket disability insurance forms, certification not permitted.
284-58-120	Blanket disability insurance forms which may be filed by certification.
284-58-130	Individual life insurance and annuity forms, certification not permitted.
284-58-140	Individual life insurance and annuity forms which may be filed by certification.
284-58-150	Group life insurance and annuity contract forms, certification not permitted.
284-58-160	Group life insurance and annuity forms which may be filed by certification.
284-58-170	Credit insurance forms, certification not permitted.
284-58-180	Fraternal benefit society forms.
284-58-190	Certification form to be used for disability insurance form filings.
284-58-200	Form to be used for certification of disability insurance form or rate filings.
284-58-210	Certification form to be used for life insurance and annuity form filings.
284-58-220	Form to be used for certification of life insurance or annuity form filings.
284-58-250	General contents of a form filing for property and casualty insurance and kinds of insurance other than life and disability.
284-58-260	Designation of forms for insurances other than life and disability which may not be filed by certification.
284-58-270	Certification form to be used for property and casualty insurance.
284-58-280	Form to be used for certification of property or casualty insurance form filings.

WAC 284-58-010 Title and purpose. (1) This chapter, WAC 284-58-010 through 284-58-280, shall be known and may be cited as the Washington state form filing requirements.

(2) The purpose of this chapter is to establish the necessary contents of a form filing, including the documents to be used in connection with a form filing, to designate the types of policy forms which may not be filed by certification pursuant to RCW 48.18.100(2), and, with respect to disability insurance, to establish the filing requirements with respect to manuals of classification, manual of rules and rates, and modifications thereof.

(3) The fees for filing both forms and rates, and the definitions of such filings for purposes of determining the proper filing fees, are set forth in WAC 284-14-010. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-010, filed 11/5/82.]

WAC 284-58-020 Scope and general contents. (1) This regulation applies to all insurers and to all forms required to be filed with the commissioner pursuant to RCW 48.18.100, and to all manuals of classification,

manuals of rules and rates and modifications thereof required to be filed with respect to disability insurance pursuant to RCW 48.19.010(2).

(2) RCW 48.18.100 establishes two basic types of form filings. The first type contemplates the approval of the commissioner. The second type contemplates a filing containing a certification, which permits the insurer to use the form without approval, immediately after the filing. The first, or approval, type of filing requires the commissioner to act within fifteen days (or thirty days, if extended pursuant to RCW 48.18.100(3)), and, if the form has not been either approved or disapproved during such time period, the form is deemed approved and may be used by the insurer. In either case, the commissioner may subsequently withdraw approval or stop the use of a form for cause.

(3) This chapter is divided into the following parts:

(a) The general contents of a life or disability insurance form filing and the reporting documents to be used are set forth in WAC 284-58-030 through 284-58-060.

(b) Designations of the types of life and disability insurance forms which may and may not be filed by the "certification" procedure are found in WAC 284-58-070 through 284-58-180.

(c) Procedures and forms for the certification of life and disability insurance forms and rates begin with WAC 284-58-190.

(d) The general contents of a form filing for property and casualty or kinds of insurance other than life and disability, required to be made pursuant to RCW 48.18.100, are set forth in WAC 284-58-250.

(e) Designation of the types of forms for insurances other than life and disability which may not be filed by the "certification" procedure is set forth in WAC 284-58-260.

(f) The form to be used for the certification of forms for insurances other than life and disability is set forth in WAC 284-58-280. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-020, filed 11/5/82.]

WAC 284-58-030 General contents of all life and disability form and disability rate filings. Each life or disability insurance form filing submitted to the commissioner, whether for approval or by certification, shall contain the following materials arranged in this order:

(1) The appropriate filing fee as prescribed by WAC 284-14-010, and the filing transmittal information required by WAC 284-14-020 separately attached to each form being filed;

(2) One filing report as required by WAC 284-58-040 and, if applicable, a certification prepared pursuant to WAC 284-58-190 or 284-58-210, as appropriate;

(3) The printed form or forms, completed in John Doe fashion if appropriate;

(4) Rates, manuals of classification, manuals of rules and rates and modifications thereof, if appropriate;

(5) Actuarial memorandum of nonforfeiture values, if appropriate;

(6) Actuarial demonstration of anticipated loss ratio, if appropriate; and

(7) Any additional required enclosure. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-030, filed 11/5/82.]

WAC 284-58-040 Life and disability filing report documents. Filing report documents have been established to facilitate and expedite the forms review process with respect to life and disability insurance and must be used with every form filing. A cover letter will not be necessary except with respect to an exceptional filing. The filing report document to be used for life and disability form filings is set forth in WAC 284-58-050. The filing report document to be used for disability insurance rates is set forth in WAC 284-58-060. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-040, filed 11/5/82.]

WAC 284-58-050 Document to be used in filing life and disability forms.

STATE OF WASHINGTON
FILING REPORT - LIFE AND DISABILITY
FORMS

(This report must accompany each filing of life and disability forms submitted to the Washington State Insurance Commissioner.)

- 1. Company Name:
- 2. Date of Submission:
- 3. Company Mailing Address:
- 4. Check if the form(s) will be used for Blanket (), Franchise (), or Mass-marketing purposes ().
- 5. This filing is made for () Approval by the Commissioner or () As a Certified Filing — Certificate attached

6. Type of Filing:

Form or Group of Similar Forms*	Form #	Forms to be replaced. Give form numbers
() Policy
() Application
() Rider
() Endorsement
() Amendment
() Other

*An example of a group of similar forms would be a set of decreasing term forms, but not including any renewable term or permanent plans with policy provisions different from those of a decreasing term form.

7. Date(s) of Domiciliary Form(s) Approval: -----, -----, -----

- 8. What line of insurance is involved?
 - Group
 - Blanket
 - Individual
 - Franchise
 - Mass Marketed Individual Forms
 - Other, please explain in a cover letter
- 9. If an individual policy form is being filed, what type of product is involved?
 - Universal Life
 - Indeterminate Premium Life
 - Adjustable - Optional Increases in Face
 - Fixed Benefit, Fixed Level Premium Life
 - Graded Benefit or Graded Premium Life
 - Deposit Term or Deposit Permanent
 - Reentry Term
 - Reversion Privilege Term
 - Retired Lives Reserve
 - Flexible Premium Annuity
 - Savings Annuity
 - Reversionary Annuity
 - Fixed Premium Annuity
 - Accident Only
 - Health
 - Monthly Income Disability
 - Medicare Supplement
 - Credit
 - Separate Account Insurance Forms
 - Other, please explain in a cover letter
- 10. Check here if there are any unusual features or provisions in this filing. Examples include variable premiums and coverages, limited markets or unusual underwriting. If checked, explain fully in a cover letter.
- 11. Check here if this filing contains any provisions previously disapproved by this office. If checked, describe fully in a cover letter.
- 12. List other health insurance forms of the same generic type presently marketed. If such other forms are of nearly identical benefits, explain the need for this form in a cover letter.
- 13. Check here if the form is filed as a result of a change in a Washington statute or regulation. Please give citation:
- 14. Check here if the forms filed are substantially identical to other forms recently approved in Washington. State the form numbers and indicate the provisions which differ. -----, -----, -----, -----, -----
- 15. Check here if this form is to be issued to a trust. (The certificate issued to the participant must be filed.)
- 16. _____
Signature of designated representative with whom this submission may be discussed

Name printed or typed with title

Telephone number _____

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-050, filed 11/5/82.]

WAC 284-58-060 Document to be used in filing disability rates.

STATE OF WASHINGTON
FILING REPORT - DISABILITY RATES

(This report must accompany each filing of disability insurance rates submitted to the Washington State Insurance Commissioner.)

- 1. Company Name: 2. Date of Submission:
- 3. Company Mailing Address:
- 4. Line of disability insurance involved?
 - Group
 - Blanket Insurance
 - Individual
 - Franchise
 - Mass Marketed Individual Forms
- 5. Type of disability insurance product involved:
 - Accident Only
 - Health with Substantial Inside Limits
 - Health Insurance without Substantial Inside Limits
 - Monthly Income Disability
 - Medicare Supplement
 - Credit
- 6. Type of Filing:

Rates to be used with insurance form or group of similar forms*

- Initial Filing of Rates
- Rate Increase/Decrease
- Automatic Medicare Rate Increase
- Rate Deviation Credit Insurance
- Other

*An example of a group of similar forms would be those grouped together for morbidity experience studies or for pricing purposes where similar experience is expected, such as a group of major medical policies with different deductible amounts.

- 7. This filing is made for Approval by the Commissioner or As a Certified Filing - Certificate attached

8. Date(s) of Domiciliary Form(s) and Rate Approval(s): -----, -----

- 9. Give the approval date of the form(s) and the effective date(s) of any rate increase(s) in the state of Washington.
Form Numbers: -----, -----, -----, -----,
-----, -----
Previous rate increases -----, -----, -----,
-----, -----.
- 10. What is the scope and reason for the rate increase?
(Enclose actuarial justification and demonstration.)
- 11. Does the filing apply to: () new business, () to
in force business, () both? State reasons therefor.
- 12. To what degree is it anticipated that this rate in-
crease will result in additional lapses and worsened
morbidity experience.
- 13. () Check here if there are any unusual features
or provisions to this filing requiring special
rate considerations. If checked, explain fully
in a cover letter.
- 14. () Check here if this filing contains any rates
previously disapproved by this Office. If
checked, describe fully in a cover letter.
- 15. List other health insurance forms of the same ge-
neric type presently marketed. Explain in a cover
letter if such forms were grouped together with
form(s) of this filing for pricing or experience
study purposes, but are now kept separate.
- 16. () Check here if the rates are filed as a result of
a change in a Washington statute or regula-
tion concerning policy benefits or rate struc-
ture. Please give the citation:
- 17. () Check here if the rates filed are for forms
similar to other forms recently approved in
Washington. Please list the form numbers:
-----, -----, -----, -----, -----
- 18.
Signature of designated representative
with whom this filing may be discussed
.....
Name printed or typed with title
.....
Telephone number

[Statutory Authority: RCW 48.02.060. 82-23-009 (Or-
der R 82-5), § 284-58-060, filed 11/5/82.]

**WAC 284-58-070 General designation of life and
disability forms which may not be filed by certification.**
The following categories of life and disability forms may
never be filed through the certification process, but must
be filed for approval:

(1) Forms of a type not previously reviewed and ap-
proved in the state of Washington for the particular fil-
ing company, as, for example, when a company enters a

new segment of the insurance market such as a life in-
surer first entering the group or credit insurance market.

(2) Any form containing unusual features or provi-
sions. Examples include variable premiums and cover-
ages, limited markets or unusual underwriting.

(3) Any form containing any provision previously dis-
approved by this state. [Statutory Authority: RCW 48-
.02.060. 82-23-009 (Order R 82-5), § 284-58-070,
filed 11/5/82.]

**WAC 284-58-080 Individual disability insurance
forms, certification not permitted.** No individual disabili-
ty insurance forms may be filed by the certification
process. All must be filed for approval. [Statutory Au-
thority: RCW 48.02.060. 82-23-009 (Order R 82-5), §
284-58-080, filed 11/5/82.]

**WAC 284-58-090 Group disability insurance forms,
certification not permitted.** The following types of group
disability insurance forms may not be filed by certifica-
tion process, but must be filed for approval:

(1) Medicare supplement insurance forms.

(2) Forms to be used with association groups as de-
fined in RCW 48.24.045.

(3) Forms to be used with debtor groups as defined in
RCW 48.24.040.

(4) Excess risk or loss insurance.

(5) Any other form not listed in WAC 284-58-100.
[Statutory Authority: RCW 48.02.060. 82-23-009 (Or-
der R 82-5), § 284-58-090, filed 11/5/82.]

**WAC 284-58-100 Group disability insurance forms
which may be filed by certification.** Except as provided in
WAC 284-58-070, the following types of group disabili-
ty insurance forms and rates may be filed through the
certification process:

(1) Forms to be used with employee groups as defined
in RCW 48.21.010.

(2) Forms to be used with dependents' groups as de-
fined in RCW 48.24.030.

(3) Forms to be used with health care groups as de-
fined in RCW 48.21.030.

(4) Forms to be used with credit union groups as de-
fined in RCW 48.24.035.

(5) Forms to be used with labor union groups as de-
fined in RCW 48.24.050.

(6) Forms to be used with public employee associa-
tions as defined in RCW 48.24.060.

(7) Forms to be used with trustee groups as defined in
RCW 48.24.070.

(8) Forms to be used with agent groups as defined in
RCW 48.24.080.

(9) Forms to be used with financial institution groups
as defined in RCW 48.24.095.

(10) Forms to be used with a one case filing.

(11) Manuals of classification, manuals of rules and
rates, and any modifications thereof filed pursuant to
RCW 48.19.010(2). [Statutory Authority: RCW 48.02-
.060. 82-23-009 (Order R 82-5), § 284-58-100, filed
11/5/82.]

WAC 284-58-110 Blanket disability insurance forms, certification not permitted. The following types of blanket disability insurance forms may not be filed by the certification process, but must be filed for approval:

- (1) Forms submitted under RCW 48.21.040(1)(f).
- (2) Any other form not listed in WAC 284-58-120. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-110, filed 11/5/82.]

WAC 284-58-120 Blanket disability insurance forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of blanket disability insurance forms and rates may be filed through the certification process:

- (1) Forms to be used with common carrier groups, volunteer organizations, nonprofit welfare organizations, exceptional work hazards employees, and student and faculty groups, as defined in RCW 48.21.040(1) (a) through (e).
- (2) Forms to be used with a one case filing.
- (3) Manuals of classification, manuals of rules and rates, and any modifications thereof filed pursuant to RCW 48.19.010(2). [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-120, filed 11/5/82.]

WAC 284-58-130 Individual life insurance and annuity forms, certification not permitted. The following types of individual life insurance and individual annuity forms may not be filed by the certification process, but must be filed for approval:

- (1) Variable insurance forms used with a separate account.
- (2) Universal life forms.
- (3) Indeterminate premium forms.
- (4) Lower premiums for nonsmokers and other groups of better risks when such premiums are not guaranteed for the full premium paying period.
- (5) Refiling of cash values pursuant to section 14(4)(j), chapter 9, Laws of 1982 1st ex. sess.
- (6) Deposit term insurance forms.
- (7) Deposit permanent insurance forms.
- (8) Retired lives reserves.
- (9) Reentry term.
- (10) Graded premium forms.
- (11) Modified benefit forms.
- (12) Flexible premium or single premium annuity with excess interest or similar provisions.
- (13) Savings annuity.
- (14) Reversionary annuity.
- (15) Any annuity policy or rider form with a policy loan provision.
- (16) All charitable annuity forms.
- (17) All funeral insurance forms.
- (18) All coupon policy forms.
- (19) All industrial insurance forms.
- (20) Accidental death benefit riders.
- (21) Waiver of premium disability riders.
- (22) Any other form not listed in WAC 284-58-140. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-130, filed 11/5/82.]

WAC 284-58-140 Individual life insurance and annuity forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of individual life insurance and individual annuity forms may be filed through the certification process:

- (1) Level benefit, level premium, limited pay or single premium whole life contracts.
- (2) Level benefit, level premium, limited pay single premium joint whole life contracts.
- (3) Level premium endowment forms which endow for the face amount.
- (4) Single premium endowment forms which endow for the face amount.
- (5) Retirement income, income endowment, or life income to age 65 or other retirement age.
- (6) Family plans consisting of level premium, level benefit term or permanent insurance.
- (7) Level premium, level benefit term insurance whether renewable or convertible or not.
- (8) Level premium decreasing term insurance with or without nonforfeiture values.
- (9) Fixed premium or single premium deferred or immediate annuities. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-140, filed 11/5/82.]

WAC 284-58-150 Group life insurance and annuity contract forms, certification not permitted. The following types of group life insurance and group annuity forms may not be filed by the certification process, but must be filed for approval:

- (1) Variable insurance forms used with a separate account.
- (2) Forms to be used with debtor insurance groups as defined in RCW 48.24.040.
- (3) Forms to be used with association groups as defined in RCW 48.24.045.
- (4) Excess risk or loss insurance.
- (5) Any other form not listed in WAC 284-58-160. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-150, filed 11/5/82.]

WAC 284-58-160 Group life insurance and annuity forms which may be filed by certification. Except as provided in WAC 284-58-070, the following types of group life insurance and group annuity forms may be filed through the certification process:

- (1) Forms to be used with employee groups as defined in RCW 48.24.020.
- (2) Forms to be used with dependent groups as defined in RCW 48.24.030.
- (3) Forms to be used with credit union groups as defined in RCW 48.24.035.
- (4) Forms to be used with labor union groups as defined in RCW 48.24.050.
- (5) Forms to be used with public employee association groups as defined in RCW 48.24.060.
- (6) Forms to be used with trustee groups as defined in RCW 48.24.070.
- (7) Forms to be used with agent groups as defined in RCW 48.24.080.

(8) Forms to be used with financial institution groups as defined in RCW 48.24.095.

(9) Forms to be used with qualified pension plans.

(10) Forms to be used with nonqualified pension plans.

(11) Forms to be used with a one case filing. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-160, filed 11/5/82.]

WAC 284-58-170 Credit insurance forms, certification not permitted. No credit insurance forms may be filed by the certification process. All must be filed for approval. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-170, filed 11/5/82.]

WAC 284-58-180 Fraternal benefit society forms. All fraternal benefit society forms may be filed by the certification process. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-180, filed 11/5/82.]

WAC 284-58-190 Certification form to be used for disability insurance form filings. If an insurer elects to file a disability form or rate through the certification process, as permitted by this chapter, it shall complete the certification form set forth in WAC 284-58-200, which must be reproduced on paper no larger than 8-1/2 inches by 11 inches without modification, attach the certification form to the filing report document and submit the same, together with the other contents required by WAC 284-58-030, to the commissioner. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-190, filed 11/5/82.]

WAC 284-58-200 Form to be used for certification of disability insurance form or rate filings.

STATE OF WASHINGTON
CERTIFICATION
DISABILITY INSURANCE FORM(S) AND RATE
FILING

Company Name:

Form number and generic description of form to which this certification applies:

I hereby certify that to the best of my knowledge and judgment this form and rate filing is in compliance with the applicable laws and regulations of the state of Washington, that the benefits are reasonable in relation to the premiums, that formulas for loading and contingency margins are applied consistently and equitably to all the forms, benefits, issue ages, years of issue and other classifications employed including successive generic forms and generations of policyholders, that the calculations were based on my best estimate of the future experience including the need for contingency reserves and that the future experience has been projected only within a time period over which the premiums may

reasonably be expected to remain adequate. The manual rates and classifications are attached, as are loss ratio calculations for groups to which the manual rates will apply. I certify that to the best of my knowledge the form does not contain or incorporate by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

-
- Check one () Chief Executive Officer
- () Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

.....
Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-200, filed 11/5/82.]

WAC 284-58-210 Certification form to be used for life insurance and annuity form filings. If an insurer elects to file a life insurance or annuity form through the certification process, as permitted by this regulation, it shall complete a certification form the contents of which are set forth in WAC 284-58-220, which must be reproduced on paper no larger than 8-1/2 inches by 11 inches without modification, attach the certification form to the filing report document and submit the same, together with the other contents required by WAC 284-58-030, to the commissioner. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-210, filed 11/5/82.]

WAC 284-58-220 Form to be used for certification of life insurance or annuity form filings.

STATE OF WASHINGTON
CERTIFICATION
LIFE INSURANCE AND ANNUITY FORM
FILINGS

Company Name:

Form number and generic description of form to which this certification applies:

I have prepared or supervised the preparation of the actuarial formula for this policy. The actuarial demonstrations are attached. I certify that the nonforfeiture benefits for this form, for every age and face amount combination are in compliance with the applicable laws and regulations of the state of Washington. I certify that

to the best of my knowledge and judgment, this form is in compliance with the applicable laws and regulations of the state of Washington, and the form does not contain or incorporate any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

-
- Check one () Chief Executive Officer
- () Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

.....
Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-220, filed 11/5/82.]

WAC 284-58-250 General contents of a form filing for property and casualty insurance and kinds of insurance other than life and disability. Each form filing for property and casualty insurance or kinds of insurance other than life and disability, whether for approval or by certification, shall contain the following:

- (1) A completed filing transmittal information form as prescribed in WAC 284-14-020. (If the form being filed is a revision or replacement of an existing form, include or attach a summary of the change being made.)
- (2) If applicable, a completed certification form as prescribed in WAC 284-58-270.
- (3) The printed form or forms, in duplicate.
- (4) The appropriate filing fee as prescribed by WAC 284-14-010. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-250, filed 11/5/82.]

WAC 284-58-260 Designation of forms for insurances other than life and disability which may not be filed by certification. (1) Except as provided in subsection (2) of this section, every property or casualty insurance policy form and endorsement pertaining to the following types of insurance must be filed for approval and may not be filed through the certification process.

- (a) Fire and allied lines;
- (b) Farmowners multiple peril;
- (c) Homeowners multiple peril;
- (d) Commercial multiple peril;
- (e) Inland marine;
- (f) Professional liability;
- (g) Earthquake;

- (h) Private passenger automobile;
- (i) Commercial automobile;
- (j) General liability;
- (k) Glass;
- (l) Crime coverage;
- (m) Boiler and machinery; and
- (n) Credit.

(2) Whenever a policy form or endorsement identified in subsection (1) of this section has been filed by a rating organization with, and approved by, the commissioner, a form with identical substantive wording may be filed by an individual insurance company by the certification process. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-260, filed 11/5/82.]

WAC 284-58-270 Certification form to be used for property and casualty insurance. If an insurer elects to file a property or casualty insurance form, or a form for a kind of insurance other than life and disability, through the certification process, as permitted by this chapter, it shall complete a certification form, the contents of which shall be as set forth in WAC 284-58-280, and submit such certification form, together with the other contents required by WAC 284-58-250, to the commissioner. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-270, filed 11/5/82.]

WAC 284-58-280 Form to be used for certification of property or casualty insurance form filings.

CERTIFICATION OF FORM (for other than life or disability insurance)

To the Washington State Insurance Commissioner

Pursuant to RCW 48.18.100 and WAC 284-58-270, I certify to the best of my knowledge and belief that each insurance policy form annexed hereto and filed herewith is in compliance with Title 48 RCW and Title 284 WAC.

(Type or print company's name:)

(Signature)

-
- Check one () Chief Executive Officer
- () Actuary and Member of American Academy of Actuaries

Please type or print name of person, and title, whose signature appears above.

.....
Date:
Telephone No.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-280, filed 11/5/82.]