

275-91-070 Supplemental care. [Order 1252, § 275-91-070, filed 11/21/77.] Repealed by 84-16-066 (Order 84-11), filed 7/30/84, effective 9/4/84. Statutory Authority: RCW 72.01.050, 72.01.090 and 72.09.050. Later promulgation, see WAC 137-91-070.

WAC 275-91-011 through 275-91-070 Repealed.
See Disposition Table at beginning of this chapter.

Chapter 275-92 WAC

**ADULT CORRECTIONAL INSTITUTIONS--
RELEASE PROGRAMS--WORK TRAINING**

WAC

275-92-407 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

275-92-407 Supervision--Individual work release placement. [Statutory Authority: RCW 72.65.100. 81-05-001 (Order 1595), § 275-92-407, 2/5/81.] Repealed by 85-08-022 (Order 85-05), filed 4/1/85. Statutory Authority: RCW 72.65.100.

WAC 275-92-407 Repealed. See Disposition Table at beginning of this chapter.

Chapter 275-110 WAC

**IMPACT ACCOUNT--CRIMINAL JUSTICE COST
REIMBURSEMENT**

WAC

275-110-040 Institutions and eligible impacted political subdivisions.

WAC 275-110-040 Institutions and eligible impacted political subdivisions. Reimbursement shall be limited to the following city, town, and county governments impacted by the offenses from inmates assigned to institutions listed in this section.

Institution	Cities/County
(1) Washington state penitentiary	Walla Walla/Walla Walla
(2) Washington state reformatory	Monroe/Snohomish
(3) McNeil Island corrections center	Steilacoom/Pierce
(4) Washington corrections center	Shelton/Mason
(5) Purdy treatment center for women	Gig Harbor/Pierce
(6) Firland correctional center	Seattle/King
(7) Larch corrections center	Yacolt/Clark
(8) Clearwater correctional center	Forks/Clallam
(9) Olympic corrections center	Forks/Clallam
(10) Indian Ridge treatment center	Arlington/Snohomish
(11) Pine Lodge correctional center	Medical Lake/Spokane/Spokane
(12) Cedar Creek correctional center	Littlerock/Thurston
(13) Special offender center	Monroe/Snohomish
(14) Echo Glen children's center	Snoqualmie/King
(15) Green Hill school	Chehalis/Lewis
(16) Maple Lane school	Rochester/Thurston
(17) Mission Creek youth camp	Belfair/Mason
(18) Naselle youth camp	Naselle/Pacific
(19) Woodinville group home	Woodinville/King
(20) Canyon View group home	East Wenatchee/Douglas

Institution

- (21) Sunrise group home
- (22) Twin Rivers group home
- (23) Oakridge group home
- (24) Park Creek group home
- (25) Ridgeview group home
- (26) Western state hospital
- (27) Eastern state hospital

Cities/County

- Ephrata/Grant
- Richland/Benton
- Tacoma/Pierce
- Kittitas/Kittitas
- Yakima/Yakima
- Steilacoom/Pierce
- Medical Lake/Spokane/Spokane

- (28) Child study and treatment center

Steilacoom/Pierce

(29) For any institution not listed in this section, reimbursement shall be limited to the political subdivisions where the institution is located. Such institutions include adult work release facilities and juvenile group homes housing inmates as defined in WAC 275-110-020(7). [Statutory Authority: RCW 13.06.030, 13.40.210 and 72.72.040. 85-09-003 (Order 2221), § 275-110-040, filed 4/4/85. Statutory Authority: RCW 72.72.040. 81-15-061 (Order 1682), § 275-110-040, filed 7/20/81; 80-17-004 (Order 1569), § 275-110-040, filed 11/7/80; 80-02-109 (Order 1482), § 275-110-040, filed 1/25/80.]

Title 284 WAC

INSURANCE COMMISSIONER

Chapters

- 284-17 Licensing requirements and procedures.
- 284-19 Washington essential property insurance inspection and placement program.
- 284-24 Rates.
- 284-30 Trade practices.
- 284-44 Health care services contractors--Agents--Contract formats--Standards.
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Chapter 284-17 WAC

LICENSING REQUIREMENTS AND PROCEDURES

WAC

- 284-17-120 Examination procedures for agents, solicitors and adjusters.
- 284-17-400 Renewal dates for agents, brokers, solicitors and adjusters.
- 284-17-410 Appointment renewal and termination procedures for insurance agents.
- 284-17-420 Appointment, affiliation and renewal procedures for licensed persons empowered to exercise the authority conferred to a corporate or firm licensee.

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 the independent testing service. Such fee is not refundable. Registration forms and information about examinations may be obtained from the office of insurance commissioner or from the independent testing service.

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

TYPE OF LICENSE	EXAMINATION(S) REQUIRED
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
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 and 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, or 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 the independent 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, the appropriate license fee and filing fee.

(5) An applicant who fails to pass the insurance agent, solicitor or adjuster examination may request reexamination 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. 84-19-022 (Order R 84-3), § 284-17-120, filed 9/12/84; 82-10-016 (Order R 82-2), § 284-17-120, filed 4/28/82.]

WAC 284-17-400 Renewal dates for agents, brokers, solicitors and adjusters. New licenses will be valid for a period ending with the licensee's first birthday anniversary after the initial issue date in the case of individuals, and for a period ending with the first renewal date after the initial issue date in the case of firms or corporations. Thereafter, such licenses will be renewed for a period of one year. [Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-400, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-400, filed 3/20/80.]

WAC 284-17-410 Appointment renewal and termination procedures for insurance agents. (1) Appointments shall be valid for a period ending with the insurer's first renewal date after the initial issue date. Such renewal date is assigned by the office of the insurance commissioner. Thereafter, all appointments will be renewed for a period of one year.

(2) Revocations of agents' appointments by the insurer are governed by RCW 48.17.160(4).

(3) Termination of an appointment by the agent may be accomplished by the agent giving advance written notice to the insurer with a copy mailed to the insurance commissioner that, as of a date stated in such notice, the agent renounces the appointment and will no longer represent the insurer as its agent. [Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-410, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-410, filed 3/20/80.]

WAC 284-17-420 Appointment, affiliation and renewal procedures for licensed persons empowered to exercise the authority conferred to a corporate or firm licensee. (1) Each firm or corporation licensed as an insurance agent must be appointed by an insurer or insurers as required by RCW 48.17.160 as a prerequisite to the sale of insurance: *Provided*, That individual licensees who are empowered to exercise the authority conferred by the corporate or firm license need not be individually appointed by insurers.

(2) All firms or corporations licensed as an agent, adjuster or broker shall notify the office of the insurance commissioner of all persons who are empowered to exercise the authority conferred by the firm or corporate license. For purposes of this section, such persons shall be defined as "affiliated" with the licensed firm or corporation.

(3) An affiliation by a licensed firm or corporation which is not revoked or renounced shall be valid until the firm's or corporation's first renewal date after the notice. Thereafter, each affiliation may be renewed for a period of one year, subject to the firm or corporation paying the annual affiliation renewal fee which shall be the same as the agent appointment renewal fee.

(4) When the appointment of an affiliated person is revoked by a firm or corporation, written notice of such revocation shall be given to the affiliated person and a copy of the notice of revocation shall be mailed to the commissioner.

(5) Termination of an appointment by an affiliated person may be accomplished by such person giving advance written notice to the firm or corporation with a copy mailed to the insurance commissioner that, as of a date stated in such notice, the affiliated person renounces the appointment and will no longer act on behalf of the firm or corporation. [Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-420, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-420, filed 3/20/80.]

Chapter 284-19 WAC
WASHINGTON ESSENTIAL PROPERTY
INSURANCE INSPECTION AND PLACEMENT
PROGRAM

WAC
 284-19-200 Termination of program.

WAC 284-19-200 Termination of program. This program shall terminate upon repeal of this regulation (chapter 284-19 WAC). In the event of the expiration of the act or the failure of the program to continue to qualify for riot or civil disorder reinsurance under the act, the program shall continue for an additional four years from the earlier of such expiration or failure to qualify for reinsurance, and, during such additional years, the facility, association and governing committee shall continue to function in conformity with chapter 284-19 WAC except with respect to references to the act or the secretary as the same become inapplicable and except that no insurance policy under the program shall be issued or renewed during the final year. No obligations incurred by the association shall be impaired by the termination of the program and such association shall be continued for the purpose of performing such obligations. [Statutory Authority: RCW 48.02.060. 84-23-006 (Order R 84-5), § 284-19-200, filed 11/8/84; Order R 77-1, § 284-19-200, filed 3/24/77; Order R-73-2, § 284-19-200, filed 3/30/73; Order R-69-1, § 284-19-200, filed 1/28/69.]

Chapter 284-24 WAC
RATES

WAC
 284-24-100 Standards for schedule rating plans, noncomplying filings ineffective.

WAC 284-24-100 Standards for schedule rating plans, noncomplying filings ineffective. Pursuant to RCW 48.19.120, and to effectuate the provisions of RCW 48.19.030, the commissioner finds that existing schedule rating plans permit excessive credits or debits, commonly resulting in discrimination against insureds or inadequate premiums, and, for that reason, fail to meet the requirements of chapter 48.19 RCW. Therefore, no filing of a schedule rating plan shall be effective or accepted after January 1, 1986, unless it meets the following standards:

(1) A plan shall apply only to those classes of insurance (monoline or packaged) commonly known as commercial vehicle, commercial general casualty, commercial inland marine, and commercial property.

(2) A plan shall provide for no more than a twenty-five percent credit (reduction) or debit (charge), excluding any expense adjustment permitted by a lawfully filed and approved expense adjustment plan.

(3) A plan must provide for an objective analysis by the insurer of the risk and be based on specific factual information supporting the rating. Items such as the following may be considered:

(a) Management capacity for loss control and risk improvement, including financial and operating performance.

(b) Condition and upkeep of premises and equipment.

(c) Location of risk and suitability of occupancy.

(d) Quality of fire and police protection.

(e) Employee training, selection, supervision, or similar elements.

(f) Type of equipment.

(g) Safety programming.

(h) Construction features and maintenance.

(i) Classification variances, including differences from average hazards.

(4) A plan must provide that when a risk is rated below average (debited), an insured or applicant, upon timely request, will be advised by the insurer of the factors which resulted in the adverse rating so that the insured or applicant will be fairly apprised of any corrective action that might be appropriate with respect to the insurance risk.

(5) A plan shall be administered equitably and applied fairly to every eligible risk which an insurer elects to insure. Records supporting the development of individual risk modifications shall be retained by the insurer for a minimum of three years or until the conclusion of the next regular examination conducted by the insurance department of its domicile, whichever is later, and made available at all reasonable times for the commissioner's examination. Such records must include copies of all documentation used in making each particular determination, even though a credit or debit may not result. [Statutory Authority: RCW 48.02.060. 85-23-031 (Order R 85-4), § 284-24-100, filed 11/14/85.]

Chapter 284-30 WAC
TRADE PRACTICES

WAC
 284-30-390 Standards for prompt, fair and equitable settlements applicable to automobile insurance.
 284-30-500 Unfair practices with respect to vehicle insurance.
 284-30-550 Receipts to be given.
 284-30-560 Applications and binders.
 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed.
 284-30-580 Policies to be delivered, not held by agents.
 284-30-600 Unfair practices with respect to out of state group life and disability insurance.
 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations.

WAC 284-30-390 Standards for prompt, fair and equitable settlements applicable to automobile insurance. The following standards apply to insurance claims relating to motorcycles and private passenger automobiles as defined in RCW 48.18.297: (1) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(a) The insurer may elect to offer a replacement automobile which is a specific comparable automobile

available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(b) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fee incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by

(i) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area.

(ii) One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.

(c) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (1)(a) and (1)(b) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

(2) Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(3) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop, or to obtain a temporary rental or loaner automobile.

(4) Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(5) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be itemized and shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and shall, upon request, furnish to the claimant the names of repair shops convenient to the claimant that will satisfactorily complete the repairs for the estimated cost, having in mind, particularly, the problems associated with the repair of unibody vehicles.

(6) In first party claim situations, if an insurer elects to exercise a contract right to repair and designates a specific repair shop for automobile repairs, the insurer

shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(7) In any claim situation, an insurer shall make a good faith effort to honor a claimant's request for repairs to be made in a specific repair shop of the claimant's choice, and shall not arbitrarily deny such request. A denial of such a request solely because of the repair shop's hourly rate is arbitrary if such rate does not result in a higher overall cost of repairs. The insurer shall make an appropriate notation in its claim file setting forth the reason it has rejected a claimant's request.

(8) Deductions for betterment and depreciation are permitted only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and depreciation shall be limited to the lesser of an amount equal to the proportion that the expired life of the part to be repaired or replaced bears to the normal useful life of that part, or the amount which the resale value of the vehicle is increased by the repair or replacement. Calculations for betterment, depreciation, and normal useful life must be included in the insurer's claim file. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-390, filed 12/27/84. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-390, filed 7/27/78, effective 9/1/78.]

WAC 284-30-500 Unfair practices with respect to vehicle insurance. (1) Beginning July 1, 1985, the following practices by any insurer with respect to every vehicle liability insurance policy applicable to private passenger automobiles registered or principally garaged in this state are unfair and prohibited:

(a) Failing to provide, to any insured under such policy, liability limits at least as great as those required by RCW 46.29.090, as measured at the effective date of the pertinent policy or its renewal;

(b) Denying or limiting liability coverage in such policy to less than the limits required by RCW 46.29.090, solely because the injured person is related to the insured by blood or marriage, as, for example, through use of so-called "family" or "household" exclusions;

(c) Denying or limiting liability coverage in such policy, with respect to injuries sustained by motorcycle passengers, to an amount below the bodily injury liability limits required by RCW 46.29.090.

(2) Beginning July 1, 1985, the following practices by any insurer, with respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, are unfair and prohibited:

(a) Failing to provide a named insured under such policy an itemization of the premium costs for the coverages under the policy as to which there are identifiable separate premium charges. Such itemization shall be given no later than the time of delivery of a policy and with each offer to renew thereafter;

(b) Failing, except with respect to a motorcycle policy, to provide, to any named insured who so requests

and pays the premium therefor, first party automobile benefits such as those in medical payments coverage or personal injury protection, on approved forms commonly used by the insurer in the state of Washington, with maximum benefit limits, as appropriate to the particular form, of at least:

(i) \$35,000 for medical and hospital benefits incurred within three years of the accident;

(ii) \$35,000 for one year's income continuation benefits, subject to a limit of the lesser of \$700 per week or eighty-five percent of the weekly income; and

(iii) \$40 per day for loss of services benefits, for at least a year.

(3) For purposes of this section, the definition of a "private passenger automobile" is that set forth in RCW 48.18.297, and includes a motorcycle except as otherwise specifically provided in this section. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-500, filed 12/27/84.]

WAC 284-30-550 Receipts to be given. (1) Beginning June 1, 1985, to effectuate RCW 48.17.470 and 48.17.480 and to eliminate unfair practices in accord with RCW 48.30.010, any agent, solicitor or other representative of an insurer who receives a contract payment or premium from or on behalf of an insured or applicant for homeowners', dwelling fire, private passenger automobile, motorcycle, individual life, or individual disability insurance shall deliver or mail a signed receipt therefor as promptly as possible, which should generally be no later than the next business day. Such receipt must be dated, identify the agent and the agent's address, identify the person by or for whom payment is made, state the amount received, identify the applicable insurer by its full legal name (or the premium finance company or Washington automobile insurance plan if payment is intended therefor), and identify the contract or policy including a brief description of the coverage for which payment is received.

(2) The receipt need not be an independent document but may be incorporated in an application or binder, if appropriate.

(3) For purposes of this section "life insurance" includes annuities.

(4) For purposes of this section "insurer" includes a health care service contractor and a health maintenance organization, and "disability insurance" includes their contracts and agreements.

(5) This section shall not apply to the receipt of checks or other instruments payable on their face to the insurer, premium finance company or the Washington Automobile Insurance Plan. It also shall not apply to payments (other than by cash) received by an agent after delivery of the policy for which payment is made, when the payment is pursuant to a premium financing arrangement with the agent or in response to a billing by the agent.

(6) A failure to comply with this section shall be an unfair practice pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.17.530.

(7) Each insurer shall inform its agents and appropriate representatives of the requirements of this section. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-550, filed 12/27/84.]

WAC 284-30-560 Applications and binders. (1) Beginning June 1, 1985, every application form used in connection with homeowners', dwelling fire and vehicle insurance, shall contain a clear and conspicuous statement setting forth whether or not coverage has commenced.

(a) If coverage has commenced, the effective date shall be stated.

(b) If coverage has not commenced, there shall be an explanation as to the circumstances which will cause coverage to commence and the time when coverage will become effective.

(c) The statement concerning commencement of coverage shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the other contents of the application so as to be confusing, misleading or not readily evident.

(d) A copy of such application shall be delivered or mailed to the applicant promptly following its execution.

(2) Beginning June 1, 1985, every binder used pending the issuance of a policy of property, marine and transportation, vehicle and general casualty insurance, as those kinds of insurance are defined in chapter 48.11 RCW, shall be reduced to writing or printed form and delivered or mailed to the insured as promptly as possible, which should generally be no later than the next business day.

(a) Such binder must be dated, identify the insurer in which coverage is bound, briefly describe the coverage bound, state the date and time coverage is effective, and acknowledge receipt of the amount of any premium money received.

(b) Such binder may be incorporated in or be attached to the application for the insurance but must be clear and conspicuous.

(3) Binders should be replaced promptly with insurance policies. With few exceptions and then only in compliance with RCW 48.18.230(2), insurers must replace binders within ninety days of their effective date.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-560, filed 12/27/84.]

WAC 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed. Whenever an insurer is required by law to give the reason for its canceling, denying, or refusing to renew insurance, as, for example, pursuant to RCW 48.18.291,

48.18.292, or 48.30.320, it shall give the true and actual reason for its action in clear and simple language, so that the insured or applicant will not need to resort to additional research to understand the real reason for the action. It is not sufficient, for example, to state that an insured "does not meet the company's underwriting standards." The reason why the individual does not meet such underwriting standards is what must be given. If the actual reason relates to medical information, the insurer may make a broad reference thereto and limit specific disclosure of details to the applicant's or insured's physician. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-570, filed 12/27/84.]

WAC 284-30-580 Policies to be delivered, not held by agents. (1) RCW 48.18.260 requires that policies be delivered within a reasonable period of time after issuance. If an insurer relies upon its agents to make deliveries of its policies, the insurer, as well as the agent, is responsible for any delay resulting from the failure of the agent to act diligently.

(2) Insurance agents delivering insurance policies to insureds must make an actual physical delivery. It is not acceptable for an agent to merely obtain a receipt indicating a delivery and then to retain the policy, for safekeeping or otherwise, in the agent's possession.

(3) Agents may obtain policies from owners or insureds and hold such policies briefly for analysis or servicing, giving a receipt therefor in every instance, but shall promptly return any such policies to their owners or insureds. Agents shall not otherwise take custody of, or hold, insurance policies, whether for fee or at no charge, unless a family or legal relationship clearly justifies such conduct, as, for example, where a policy belonging to a minor child of the agent is held, or where the agent is acting as a legal guardian or a court appointed representative and holds a policy of a ward or of an estate.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-580, filed 12/27/84.]

WAC 284-30-600 Unfair practices with respect to out of state group life and disability insurance. (1) Beginning April 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer to effect life or disability insurance coverage on persons in this state under a group policy which is delivered to a policyholder outside this state when:

(a) With respect to disability insurance, the out of state group policy does not:

(i) Provide that claims will be processed in compliance with RCW 48.21.130 through 48.21.146,

(ii) meet the requirements as to benefits and coverage mandated by chapter 48.21 RCW, and specifically those imposed by RCW 48.21.150 through 48.21.270, and

(iii) meet the loss ratio standards applicable to group insurance pursuant to RCW 48.66.100 and 48.70.030 and WAC 284-60-060; and

(b) With respect to life insurance, the out of state group policy fails to comply with the provisions of RCW 48.24.100 through 48.24.260.

(2) This rule is applicable to insurance coverage provided by such group policies including those issued for trustee groups which would be eligible for group insurance pursuant to RCW 48.24.070, except it is not applicable to insurance coverage provided by group policies:

(a) Issued for a group which would be eligible for group insurance pursuant to RCW 48.24.020, 48.24.030, 48.24.035, 48.24.040, 48.24.050, and 48.24.095, unless the person insured pays all or substantially all of the cost of his or her coverage;

(b) Issued for an association group which would be eligible for group insurance pursuant to the requirements of RCW 48.24.045, if such association clearly has a genuine purpose and existence of significant value to its members independent of its status as the group policyholder and independent of its involvement in insurance on behalf of its members, and if, further, there is a realistic and demonstrable basis related to the situs of the association or the residencies of a substantial portion of its members justifying the issuance of the group policy in the other state; or

(c) Issued for a group which would be eligible for group insurance pursuant to RCW 48.24.060, 48.24.080, and 48.24.090.

(3) This rule is applicable whether the insurance coverage is offered by means of a solicitation through a sponsoring organization, through the mail or other mass communication media, or through licensed agents or brokers.

(4) It is further defined to be an unfair practice for any insurer effecting group insurance coverage in this state through policies issued out of state to fail with respect to such insurance:

(a) To comply with the requirements of this state relating to advertising and claims settlement practices; and

(b) To make available copies of any policy and certificates issued thereunder, and advertising materials used within this state, upon request of the commissioner. [Statutory Authority: RCW 48.02.060 (3)(a). 85-02-018 (Order R 84-7), § 284-30-600, filed 12/27/84.]

WAC 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations. (1) Beginning August 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer transacting homeowners insurance to deny homeowners insurance to an applicant therefor, or to terminate any homeowners insurance policy covering a dwelling located in this state, whether by cancellation or nonrenewal, for the principal reason that an insured under such policy is engaged in the operation of a day-care

facility, pursuant to chapter 74.15 RCW, at the insured location.

(2) This rule does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of business pursuits of an insured, specifically including those related to the operation of day-care facilities. [Statutory Authority: RCW 48.02.060, 85-17-018 (Order R 85-3), § 284-30-700, filed 8/12/85.]

Chapter 284-44 WAC

**HEALTH CARE SERVICES CONTRACTORS--
AGENTS--CONTRACT FORMATS--STANDARDS**

WAC

284-44-020	Repealed.
284-44-040	Contract standards required.
284-44-400	Assessments for examination costs.
284-44-410	Form for reporting number of persons entitled to services.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-44-020	Agents, licensing or appointment required. [Order R-74-1, § 284-44-020, filed 6/4/74, effective 8/1/74.] Repealed by 84-08-001 (Order R 84-1), filed 3/22/84. Statutory Authority: RCW 48.44.050.
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WAC 284-44-020 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-44-040 Contract standards required. Every health care service contract issued or renewed after December 31, 1974, shall conform to the following standards:

(1) A contract shall not unreasonably limit benefits to a specified period of time. For example, a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided, is not acceptable. Contracts may, however, limit major medical benefits, supplemental accident benefits, and diagnostic x-ray and laboratory benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, in the case of doctor calls, to a reasonable number of calls over a stated period of time.

(2) A contract must provide that reasonable benefits will be restored upon each renewal of the contract or upon a calendar year basis or that such benefits be reasonably continuous. It is not required that a major medical contract with a lifetime maximum benefit be renewed or restored.

(3) A contract shall not contain any provision which gives or purports to give the contractor, its agent, officer, employee, or designee the authority to make a decision relative to the contract, or coverage or claims thereunder, which is final and binding on the subscriber or beneficiary. That is, in the case of controversy arising out of the contract, a subscriber shall not be denied the right to have the controversy determined by legal or arbitration proceedings.

(4) A contract shall not contain any provision which requires a subscriber to purchase a "monthly treatment order." This prohibits provisions that require a subscriber to pay a special charge, distinct from the prepayment fees required of all subscribers and coinsurance deductible amounts, in order to obtain advance authorization for treatment or services.

(5) If a contract restricts treatment to services by the contractor's participants or agents, a reasonable provision shall be included to allow emergency treatment consistent with the scope of the benefits regularly provided by the contract.

(6) If a contract provides maternity benefits, there shall be no waiting period for maternity benefits in advance of a conception occurring while the contract is in force.

(7) No contract shall contain any provision that unreasonably restricts or delays the payment of benefits payable under the contract. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.

(8) Every contract shall provide for a grace period of not less than ten days following the due date for the payment of the subscriber's dues, fees, or premium, during which grace period the contract shall continue in force. If payment is not made within the grace period, the contract may be terminated as of the due date of payment rather than at the end of the grace period.

(9) No contract other than a conversion contract issued pursuant to chapter 284-52 WAC shall contain any provision having the effect of coordinating benefits with other health care service contracts, health maintenance agreements, or disability insurance policies, except that group contracts may provide for coordination of benefits pursuant to chapter 284-51 WAC, and except that any contract may provide for coordination with respect to governmental programs. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200, 84-19-055 (Order R 84-4), § 284-44-040, filed 9/19/84; Order R-74-1, § 284-44-040, filed 6/4/74, effective 8/1/74.]

WAC 284-44-400 Assessments for examination costs. Assessments of health care service contractors pursuant to RCW 48.44.145(4) shall be established in the following manner:

(1) The commissioner will determine the amount expected to cover the costs of examinations of health care service contractors during a particular fiscal year, making due allowance for any amounts remaining from previous assessments carried over into a succeeding biennium.

(2) Each health care service contractor shall furnish to the commissioner, as a part of the annual financial statement required by RCW 48.44.095, the form set forth in WAC 284-44-410 indicating the number of persons entitled to health care services pursuant to an agreement under RCW 48.44.020(1), excluding such persons who are not residents of this state. It is recognized that some group subscribers do not provide a

monthly itemization of the number of covered dependents. A health care service contractor which, after reasonable effort, cannot obtain the dependency breakdown shall assume, for purposes of this section and WAC 284-44-410, that each subscriber represents two and three-fourths persons, i.e., the subscriber plus one and three-quarters dependents.

(3) The commissioner will divide the amount determined pursuant to subsection (1) of this section by the number of resident persons entitled to health care services from all health care service contractors as reported in their annual statements pursuant to subsection (2) of this section.

(4) The quotient determined pursuant to subsection (3) of this section will be adjusted to allow a reasonable margin for cost variations and rounded for ease of administration, and the resulting number, which will be the equivalent of one-half cent or less, per eligible person per month, will serve as the multiplier which the commissioner will use in calculating the amount of the assessment for each health care service contractor.

(5) The commissioner will notify each contractor of its assessment, after applying the multiplier obtained pursuant to subsection (4) of this section to the number of persons reported by the contractor pursuant to subsection (2) of this section. Payment of the assessment must be made no later than thirty days after the notice is mailed by the commissioner to the contractor.

(6) The first assessment will be based on the expected costs of examinations during the fiscal year beginning July 1, 1984, and the total number of persons reported pursuant to subsection (2) of this section as entitled to health care services during the twelve-month period ending December 31, 1983. Similarly, future assessments will be for examination costs in particular fiscal years based on the number of persons per month in the prior calendar year.

(7) The commissioner anticipates that only one assessment will be made for each fiscal year. However, if additional funds are needed to cover the costs of examinations, the commissioner may follow the procedures outlined in subsections (1) through (5) of this section to assess the contractors for the necessary additional amounts required. In any case, the portion of the cumulative amount of all assessments attributable to each month used to measure the amount of the assessment will not exceed one-half cent per person entitled to health care services during the month, pursuant to an agreement under RCW 48.44.020(1), excluding such persons who were not residents of this state. [Statutory Authority: RCW 48.44.050. 84-08-001 (Order R 84-1), § 284-44-400, filed 3/22/84.]

WAC 284-44-410 Form for reporting number of persons entitled to services.

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:

For calendar year:

Pursuant to WAC 284-44-400(2), if a health care service contractor, or WAC 284-46-010(2), if a health maintenance organization, set forth below are the numbers of persons, including dependents, who were entitled to health care services during each month of the year indicated above, excluding therefrom such persons who were not residents of this state:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Date Signed

Title.....

[Statutory Authority: RCW 48.44.050. 84-08-001 (Order R 84-1), § 284-44-410, filed 3/22/84.]

Chapter 284-46 WAC

HEALTH MAINTENANCE ORGANIZATIONS

WAC

- 284-46-010 Assessments for examination costs.
- 284-46-020 Form for reporting number of persons entitled to services.

WAC 284-46-010 Assessments for examination costs. Assessments of health maintenance organizations pursuant to RCW 48.46.120(4) shall be established in the following manner:

(1) The commissioner will determine the amount expected to cover the costs of examinations of health maintenance organizations during a particular fiscal year, making due allowance for any amounts remaining from previous assessments carried over into a succeeding biennium.

(2) Each health maintenance organization shall furnish to the commissioner, as a part of the annual financial statement required by RCW 48.46.080, the form set forth in WAC 284-46-020 indicating the number of persons entitled to health care services pursuant to an agreement as defined in RCW 48.46.020(5), excluding such persons who are not residents of this state. It is recognized that some group subscribers do not provide a monthly itemization of the number of covered dependents. A health maintenance organization which, after reasonable effort, cannot obtain the dependency breakdown shall assume, for purposes of this section and WAC 284-46-020, that each subscriber represents two and three-fourths persons, i.e., the subscriber plus one and three-quarters dependents.

(3) The commissioner will divide the amount determined pursuant to subsection (1) of this section by the

number of resident persons entitled to health care services from all health maintenance organizations as reported in their annual statements pursuant to subsection (2) of this section.

(4) The quotient determined pursuant to subsection (3) of this section will be adjusted to allow a reasonable margin for cost variations and rounded for ease of administration, and the resulting number, which will be the equivalent of one-half cent or less, per eligible person per month, will serve as the multiplier which the commissioner will use in calculating the amount of the assessment for each health maintenance organization.

(5) The commissioner will notify each organization of its assessment, after applying the multiplier obtained pursuant to subsection (4) of this section to the number of persons reported by the organization pursuant to subsection (2) of this section. Payment of the assessment must be made no later than thirty days after the notice is mailed by the commissioner to the organization.

(6) The first assessment will be based on the expected costs of examinations during the fiscal year beginning July 1, 1984, and the total number of persons reported pursuant to subsection (2) of this section as entitled to health care services during the twelve-month period ending December 31, 1983. Similarly, future assessments will be for examination costs in particular fiscal years based on the number of persons per month in the prior calendar year.

(7) The commissioner anticipates that only one assessment will be made for each fiscal year. However, if additional funds are needed to cover the costs of examinations, the commissioner may follow the procedures outlined in subsections (1) through (5) of this section to assess the organizations for the necessary additional amounts required. In any case, the portion of the cumulative amount of all assessments attributable to each month used to measure the amount of the assessment will not exceed one-half cent per person entitled to health care services during the month, pursuant to an agreement under RCW 48.46.020(5), excluding such persons who were not residents of this state. [Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-010, filed 3/22/84.]

WAC 284-46-020 Form for reporting number of persons entitled to services.

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:

For calendar year:

Pursuant to WAC 284-44-400(2), if a health care service contractor, or WAC 284-46-010(2), if a health maintenance organization, set forth below are the numbers of persons, including dependents, who were entitled to health care services during each month of the year indicated above, excluding therefrom such persons who were not residents of this state:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Date Signed.....
Title.....

[Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-020, filed 3/22/84.]

**Chapter 284-52 WAC
CONVERSION REGULATION**

WAC	
284-52-010	Purpose.
284-52-020	Mandated conversion plans minimum standards.
284-52-030	Other provisions applicable to mandated conversion plans.
284-52-040	Basic medical plan.
284-52-050	Major medical plan.
284-52-060	Comprehensive medical plan.
284-52-070	Exclusions.

WAC 284-52-010 Purpose. (1) The purpose of this chapter is to establish rules pertaining to mandated conversion plans, and their specific standards and minimum benefits, to effectuate the provisions of RCW 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460 (sections 3, 4, 6, 7, 9 and 10, chapter 190, Laws of 1984).

(2) Other conversion plans in addition to those required by this chapter may also be offered. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-010, filed 9/19/84.]

WAC 284-52-020 Mandated conversion plans minimum standards. (1) Every insurer and every health care service contractor which issues group hospital or medical benefit plans shall make available to covered persons a choice of three conversion benefit plans which meet the requirements of WAC 284-52-040, 284-52-050, and 284-52-060, and every health maintenance organization which issues group hospital or medical benefit plans shall make available a conversion benefit plan which meets the requirements of WAC 284-52-060.

(2) Chapter 190, Laws of 1984, permits a denial of conversion coverage "to a person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care." For such denial provision to apply, such other coverage must not contain operable exclusions for preexisting conditions or

waiting periods greater than those remaining under the terminated plan.

(3) Such conversion benefit plans:

(a) May provide that their benefits will be excess to any group hospital or medical plan, governmental program, or automobile medical, automobile no-fault, automobile uninsured and/or underinsured motorist or similar coverage issued to or on behalf of the covered person.

(b) Shall provide that deductible amounts will be determined on a calendar year basis.

(c) Shall provide that expenses incurred or the cost of services rendered and applied toward the annual deductible amount during the last three months of such calendar year shall be applied toward the deductible amount in the ensuing calendar year.

(d) May be rated based upon attained age.

(e) Which provide coverage for dependent children, may require evidence of insurability for newly acquired dependents except that newborn infants shall be covered from the moment of birth without evidence of insurability provided application therefor and payment of applicable rates, if any, are made within sixty days of birth.

(f) Shall permit the covered person to pay the premium monthly.

(g) Shall provide that an insured, subscriber or enrollee may continue to renew the conversion coverage until such person fails to pay a necessary premium or fee, becomes eligible for Medicare, or is covered under another group plan providing benefits for hospital and medical care, but only after preexisting conditions are covered and waiting periods have been satisfied under such plan.

(h) Which are written to cover all members of a family under one contract, shall contain a provision to assure that each member, in the event that he or she ceases to be a qualified family member for purposes of coverage, as, for example, by attaining a particular age, or through a marriage or a divorce, or by reason of death of the principal covered person, shall have the right to continue the coverage without a physical examination, statement of health, or other proof of insurability. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-020, filed 9/19/84.]

WAC 284-52-030 Other provisions applicable to mandated conversion plans. Except as otherwise required or permitted by this chapter, mandated conversion plans shall:

(1) Use a format no less favorable to the covered individual than those set forth in RCW 48.20.012, with respect to insurers, or WAC 284-44-030, with respect to health care service contractors and health maintenance organizations;

(2) Contain a provision providing for the return of the contract for a refund of payment, consistent with RCW 48.20.013, 48.44.230 or 48.46.260, as appropriate;

(3) Contain provisions consistent with and no less favorable to the covered individual than the following laws and regulations thereunder:

(a) With respect to insurers, the requirements and standard provisions set forth in chapter 48.20 RCW;

(b) With respect to health care service contractors, the requirements of chapter 48.44 RCW and WAC 284-44-040, except that lifetime maximum benefits under a conversion plan are not required to be renewed or restored;

(c) With respect to health maintenance organizations, the requirements of chapter 48.46 RCW;

(4) Be administered by the carrier in full compliance with any applicable laws which prohibit denials of payments for services performed by certain licensed providers of service. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-030, filed 9/19/84.]

WAC 284-52-040 Basic medical plan. A basic medical plan shall have an annual deductible amount of no less than five hundred dollars or more than one thousand dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of seventy-five thousand dollars per person.

(2) Daily hospital room and board expenses in an amount not less than one hundred eighty dollars per day for at least seventy days per calendar or contract year.

(3) Ancillary hospital expenses up to a maximum of eighteen hundred dollars per calendar or contract year.

(4) Surgeons' fees at the usual and customary charge up to a maximum of at least fifteen hundred dollars per surgical procedure.

(5) Usual and customary assistant surgeons' fees.

(6) Usual and customary anesthesiologists' and anesthesiologists' fees.

(7) Inpatient and outpatient physician services at the usual and customary charge. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-040, filed 9/19/84.]

WAC 284-52-050 Major medical plan. A major medical plan shall have an annual deductible amount of no less than one thousand dollars or more than five thousand dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of two hundred fifty thousand dollars.

(2) Payment of at least seventy-five percent of the usual and customary charges for the following:

(a) Daily hospital room and board expenses not less than the semi-private room rate or less than one hundred twenty days per calendar or contract year.

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthesiologists' fees.

(f) Inpatient and outpatient physician services. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-050, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-050, filed 9/19/84.]

WAC 284-52-060 Comprehensive medical plan. Except as provided in subsection (3) of this section, a comprehensive medical plan shall have an annual deductible amount of five hundred dollars per person and shall provide at least the following benefits:

(1) A lifetime maximum amount of benefits of five hundred thousand dollars per person.

(2) Payment of at least eighty percent of the usual and customary charges for the following:

(a) Daily hospital room and board expenses not less than the semi-private room rate nor less than one hundred eighty days per calendar or contract year.

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthetists' fees.

(f) Inpatient and outpatient physician services.

(3) A health maintenance organization's comprehensive medical plan may provide for no deductible amount or a deductible in any amount not exceeding five hundred dollars. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-060, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-060, filed 9/19/84.]

WAC 284-52-070 Exclusions. No policy or contract set forth in WAC 284-52-040, 284-52-050, and 284-52-060 may exclude coverage by type of illness, injury, accident, treatment, or medical condition, except with respect to the following:

(1) Mental or emotional disorders, alcoholism and drug addiction.

(2) Pregnancy, except for complications of pregnancy.

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

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

(b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury.

(c) Aviation.

(4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows covered surgery resulting from trauma, infection or other diseases of the involved part, reconstructive breast surgery covered pursuant to RCW 48.20.395, 48.21.230, 48.44.330 and 48.46.280, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

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

(6) Treatment (except emergency treatment for which legal liability exists to the covered person 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; service 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.

(7) Dental care or treatment.

(8) Eye glasses, hearing aids, and examination for the prescription or fitting thereof.

(9) Rest cures, custodial care, transportation, and routine physical examinations.

(10) Territorial limitations.

(11) Other exclusions commonly used by the particular carrier in group contracts providing hospital or medical benefits to employee groups. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-070, filed 9/19/84.]

Chapter 284-84 WAC

REGULATION FOR FIXED PREMIUM UNIVERSAL LIFE INSURANCE

WAC

284-84-010	Scope.
284-84-020	Definitions.
284-84-030	Commissioner's reserve valuation method.
284-84-040	Alternate minimum reserves.
284-84-050	Reserves, adjusting and testing.
284-84-060	Minimum cash surrender values for fixed premium universal life insurance policies.
284-84-070	Mandatory policy provisions.
284-84-080	Disclosure requirements.
284-84-090	Periodic disclosure to policyowner.
284-84-100	Unfair practices.
284-84-110	Filing requirements.

WAC 284-84-010 Scope. (1) This chapter applies to all insurers and to every individual fixed premium universal life insurance policy form, as defined in this regulation, whether solicited on an individual or mass-marketing basis, filed for approval after August 31, 1986.

(2) The approval of individual fixed premium universal life insurance policy forms approved, whether affirmatively approved or deemed approved, prior to September 1, 1986, and which are not in compliance with the provisions of this regulation on January 1, 1987, is hereby withdrawn as of January 1, 1987, and such forms shall not thereafter be delivered or issued for delivery in this state.

(3) This chapter defines unfair practices and disclosure requirements in connection with the separate accumulation of policy values granted in a rider and attached to, granted in a separate policy provision or incorporated in fixed premium universal life insurance policy forms. This chapter does not define minimum nonforfeiture provisions for the separate accumulation of funds or policy values attached to, separately granted or incorporated in fixed premium universal life insurance policy forms.

(4) This chapter does not apply to universal life insurance policies where the interest credits are linked to an external referent.

(5) This chapter does not apply to policy forms defined under chapter 48.18A RCW. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-010, filed 12/20/85.]

WAC 284-84-020 Definitions. As used in this regulation:

(1) "Universal life insurance policy" means any individual life insurance policy having provisions for separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

(2) "Flexible premium universal life insurance policy" means a universal life insurance policy which permits the policyowner to vary the amount or timing of one or more premium payments or the amount of insurance, independently of each other.

(3) "Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy. These policies typically schedule a guaranteed maximum premium at the beginning of each policy year for the premium paying period.

(4) "Cash surrender value" means the amount available in cash to the policyowner upon surrender of the policy, in the absence of any indebtedness.

(5) "Net cash surrender value" means the cash surrender value less any indebtedness under the policy.

(6) "Policy value" means the amount, developed within the main structure of the policy or provided in a separate policy provision, to which separately identified interest credits and mortality, morbidity, expense or other charges are made under a fixed premium universal life insurance policy. The policy owner may or may not have a right to the entire policy value because of built in surrender charges imposed by the insurer.

(7) "Substandard class of insureds" is one whose mortality rates are assumed to be higher than the mortality rates employed with standard issues according to the insurer's classification of risks.

(8) "Death benefit corridor" defines a minimum policy benefit payable in addition to its cash value in the event of the death of the insured. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-020, filed 12/20/85.]

WAC 284-84-030 Commissioner's reserve valuation method. The minimum valuation standard for universal life insurance policies shall be the commissioner's reserve valuation method, as hereinafter described for such policies, and the tables and interest rates hereinafter specified. The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and less (D), where:

(1) Reserves by the net level premium method shall be equal to $((A)-(B))r$ where:

(a) (A) is the present value of all future guaranteed benefits at the date of valuation.

(b) (B) is the quantity $PVFB \cdot \ddot{a}_{x+t}/\ddot{a}_x$, where PVFB is the present value of all benefits guaranteed at issue assuming future guaranteed maturity premiums are paid by the policyowner and taking into account all guarantees contained in the policy or declared by the insurer.

(c) \ddot{a}_x and \ddot{a}_{x+t} are present values of an annuity of one per year payable on policy anniversaries beginning at ages x and $x+t$, respectively, and continuing until the highest attained age at which a premium may be paid under the policy. (x) is defined as the issue age and (t) is defined as the duration of the policy.

(d) The guaranteed maturity premium for fixed premium universal life insurance policies shall be the premium defined in the policy which at issue provides the minimum policy guarantees.

(e) The guaranteed maturity premium for fixed premium policies shall be adjusted for death benefit corridors provided by the policy.

(f) r is equal to one.

(g) The guaranteed maturity fund at any duration is that amount which, together with future guaranteed maturity premiums, will mature the policy based on all policy guarantees at issue.

(2) (C) is the quantity $((a)-(b)) \cdot \ddot{a}_{x+t} \cdot r/\ddot{a}_x$, where (a)-(b) is as described in RCW 48.74.040(1) for the plan of insurance defined at issue by the guaranteed maturity premiums and all guarantees contained in the policy or declared by the insurer. The definition of \ddot{a}_{x+t} and \ddot{a}_x is set forth in subsection (1)(c) of this section.

(3) (D) is the sum of any additional quantities analogous to (C) which arise because of structural changes in the policy, with each such quantity being determined on a basis consistent with that of (C) using the maturity date in effect at the time of the change.

(a) Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(b) In effecting structural changes, consistent methods are prescribed when calculating reserves. Several such methods are possible, but perhaps the simplest such method would be that of maintaining proportionality between the guaranteed maturity fund and guaranteed maturity premium values and the current face amount. In applying this method, guaranteed maturity fund and guaranteed maturity premium values could be calculated per dollar of face amount and simply multiplied by the new face amount. This would eliminate much of the complexity involved in other methods.

(c) The guaranteed maturity premium, the guaranteed maturity fund and (B) shall be recalculated to reflect any structural changes in the policy. This recalculation shall be done in a manner consistent with the foregoing descriptions.

(4) Future guaranteed benefits are determined by (a) projecting the greater of the guaranteed maturity fund

and the policy value, taking into account future guaranteed maturity premiums, if any, and using all guarantees of interest, mortality, expense deductions, etc., contained in the policy or declared by the insurer; and (b) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

(5) All present values shall be determined using (a) an interest rate (or rates) specified by RCW 48.74.030 for policies issued in the same year; (b) the mortality rates specified by RCW 48.74.030 for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose; and (c) any other tables needed to value supplementary benefits provided by a rider which is being valued together with the policy.

(6) To the extent that the insurer declares guarantees more favorable than those in the policy (contractual guarantees), such declared guarantees shall be applicable to the determination of future guaranteed benefits.

(7) The mortality and interest bases for calculating present values are those assumptions defined in the Standard Valuation Law for the calculation of minimum policy reserves.

(8) RCW 48.74.030 (1)(g) permits valuation calculations on the basis of substandard mortality. While such provisions have been used infrequently in the past, it is anticipated that substandard mortality will be more frequently utilized in universal life insurance, given its flexible nature, to reflect the mortality classification assigned to the policy by the insurer. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-030, filed 12/20/85.]

WAC 284-84-040 Alternate minimum reserves. (1) If, in any policy year, the guaranteed maturity premium on any universal life insurance policy is less than the valuation net premium for such policy, calculated by the valuation method actually used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such contract shall be the greater of (a) or (b) of this subsection:

(a) The reserve calculated according to the method, the mortality table, and the rate of interest actually used.

(b) The reserve calculated according to the method actually used but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the guaranteed maturity premium in each policy year for which the valuation net premium exceeds the guaranteed maturity premium.

(2) For universal life insurance reserves on a net level premium basis, the valuation net premium is $\frac{PVFB}{i_x}$ and for reserves on a commissioner's reserve valuation method, the valuation net premium is $\frac{PVFB}{i_x} + \frac{((a)-(b))}{i_x}$.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-040, filed 12/20/85.]

WAC 284-84-050 Reserves, adjusting and testing.

(1) Reserves, as calculated without regard to this section, may, under some circumstances, be less than the

cash surrender value or the policy value. In such instances, the reserves shall be increased to be equal to the largest of the cash surrender value, the reserve for the policy value less the surrender charges or the policy reserve. The policy value, to the extent it is guaranteed in the present and future years, shall be prefunded in accordance with the principles of the commissioner's reserve valuation method. The policy reserve shall be calculated by the commissioner's reserve valuation method for the fixed premium fixed benefit plan with all present values based on the most conservative of the mortality and interest assumptions defined by the policy guarantees for the purpose of defining benefits, or for the purpose of valuation.

(2) For testing to see if the basic policy reserves calculation pursuant to WAC 284-84-030 is sufficient to cover a scale of cash surrender values, some of which exceed the CRVM basic policy reserves calculation in such section, or for testing a scale of gross premium rates, some or all of which may be less than the basic policy reserve valuation net premium, the mortality table and interest rates applicable at the actual date of issue for the calculation of minimum policy reserves may be used. Should such testing indicate the need for increased reserves, the reserves as calculated under the assumptions in WAC 284-84-040 would be carried.

(3) Reserves for policies where the policy value is developed within the structure of their main benefits shall employ the greater of the cash surrender value or the reserve for the policy value less the surrender charges in the testing pursuant to subsection (2) of this section. Alternatively, a separate reserve may be entered on page 3, line 11 of the statutory statement for the excess of the policy value over the guaranteed cash value.

(4) Reserves for policies where the policy value is provided in a separate policy provision shall employ the cash surrender value in the testing of such value pursuant to subsection (2) of this section and reserve for the policy value separately. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-050, filed 12/20/85.]

WAC 284-84-060 Minimum cash surrender values for fixed premium universal life insurance policies. (1) The minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

(a) The minimum cash surrender value (before adjustment for indebtedness and dividend credits) available on a date as of which interest is credited to the policy shall be equal to $((A)-(B)-(C)-(D))$, where:

(i) (A) is the present value of all future guaranteed benefits.

(ii) (B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in RCW 48.76.050 (1) and (2), or in (4)(a), as applicable. If RCW 48.76.050 (4)(a) is applicable, the nonforfeiture net level premium is equal to the quantity $\frac{PVFB}{i_x}$.

where PVFB is the present value of all benefits guaranteed at issue assuming future premiums are paid by the policyowner and all guarantees contained in the policy or declared by the insurer, and where x is the present value of an annuity of one per year payable on policy anniversaries beginning at age x and continuing until the highest attained age at which a premium may be paid under the policy.

(iii) (C) is the present value of any quantities analogous to the nonforfeiture net level premium which arise because of guarantees declared by the insurer after the issue date of the policy. x shall be replaced by an annuity beginning on the date as of which the declaration became effective and payable until the end of the period covered by the declaration.

(iv) (D) is the sum of any quantities analogous to (B) which arise because of structural changes in the policy.

(v) Structural changes are those changes which are separate from the automatic workings of the policy. Such changes usually would be initiated by the policyowner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(vi) In effecting structural changes, consistent methods are prescribed when calculating nonforfeiture values. Several such methods are possible, but perhaps the simplest such method would be that of maintaining proportionality between the guaranteed maturity fund and guaranteed maturity premium values and the current face amount. In applying this method, guaranteed maturity fund and guaranteed maturity premium values could be calculated per dollar of face amount and simply multiplied by the new face amount. This would eliminate much of the complexity involved in other methods.

(b) Future guaranteed benefits are determined by (i) projecting the policy value, taking into account future premiums, if any, and using all guarantees of interest, mortality, expense deduction, etc., contained in the policy or declared by the insurer; and (ii) taking into account any benefits guaranteed in the policy or by declaration which do not depend on the policy value.

(c) All present values shall be determined using (i) an interest rate (or rates) specified in chapter 48.76 RCW for policies issued in the same year and (ii) the mortality rates specified for policies issued in the same year or contained in such other table as may be approved by the commissioner for this purpose.

(2) Minimum paid-up nonforfeiture benefits. If a universal life insurance policy provides for the optional election of a paid-up nonforfeiture benefit, it shall be such that its present value shall be at least equal to the cash surrender value provided for by the policy on the effective date of the election. The present value shall be based on mortality and interest standards at least as favorable to the policyowner as the mortality and interest standards permitted for paid-up nonforfeiture benefits by chapter 48.76 RCW. In lieu of the paid-up nonforfeiture benefit, the insurer may provide actuarially equivalent alternatives, calculated on a guaranteed or more favorable basis defined in the policy, which provide a greater amount or longer period of death benefits, or,

if applicable, a greater amount of earlier payment of endowment benefits. Such alternative paid-up nonforfeiture benefits must be available for election by the policyowner for at least sixty days after the due date of the premium in default.

(3) Nonforfeiture benefits for substandard issues. The cash and nonforfeiture values of a substandard issue shall be calculated according to the same principles and formulas as the standard issues affording equitable treatment of the several classes of insureds. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-060, filed 12/20/85.]

WAC 284-84-070 Mandatory policy provisions. The policy shall, in addition to compliance with RCW 48.23.020, provide or comply with the following:

(1) The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised as to the status of the policy including the rights to the values and benefits. The report shall also specify the conditions, if any, that the policyowner must fulfill in order to obtain these ownerships. The end of the current report period must be no more than three months prior to the date of the mailing of the report. Specific requirements of this report are detailed in WAC 284-84-090.

(2) The policy shall provide for an illustrative report which shall be sent to the policyowner upon request. Minimum requirements of such report are set forth in WAC 284-84-080. The insurer may charge the policyowner a reasonable fee for providing the report. The amount of this fee shall be disclosed on the policy specifications page.

(3) Policy guarantees. The policy shall contain:

(a) A table of guaranteed cash surrender and nonforfeiture values and a description of the basis of their calculation.

(b) All values and data shown in the policy shall be based on the minimum guaranteed interest rate(s) and the maximum guaranteed mortality and expense charges.

(4) The policy shall contain a description of the calculation of cash surrender values deriving from the accumulation of a policy value including the following information:

(a) The guaranteed maximum expense charges and loads;

(b) The guaranteed minimum rate or rates of interest;

(c) The guaranteed maximum mortality charges;

(d) The guaranteed morbidity charges, if any;

(e) Any other guaranteed charges; and

(f) Any surrender or partial withdrawal charges.

(5) Expense charges and loads, interest credits, mortality and morbidity charges, other current charges, current surrender or partial withdrawal charges shall not remain conditional for a period longer than twelve months.

(6) If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the

policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

(7) If there is a misstatement of age or sex in the policy, the amount of the death benefit shall be that which would be purchased by the most recent mortality charge at the correct age or sex. The commissioner may approve other methods which are deemed satisfactory.

(8) The scheduled guaranteed premium shall be sufficient to fund the coverage to the termination date, if any, and to provide for the endowment, if any.

(9) If the "current" premiums are not guaranteed, they may be included in the policy if clearly labelled and identified.

(10) If the contract provides for current premiums, then it shall also disclose the duration of the insurance provided if the current premiums are paid at each policy anniversary. This disclosure shall be in close proximity to the amount of the current premium shown on the policy specifications page. The duration shall be calculated using the guaranteed policy assumptions.

(11) The policy specifications page shall contain a statement, in close proximity to the statement of the current interest to be credited the policy value, if any, that the current interest and savings in the mortality or expense charges may not be fully reflected in the policy benefits.

(12) Substandard issues. If a policy is issued to an insured in a substandard premium class, the policy must be identified as a substandard issue on the policy specifications page, along with the guaranteed and current extra premiums and an explanation of how the mortality charge applied to the policy value will be determined.

(13) The policy shall define the class of insureds in terms of each applicable pricing variable and its initial set of "current" premiums as of the date of issue.

(14) The policy shall include a provision whereby changes in the current premium and any charges or credits may only be made with respect to the entire class of insureds.

(15) The brief description on the face page shall contain the words "universal life insurance." [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-070, filed 12/20/85.]

WAC 284-84-080 Disclosure requirements. In connection with any advertising, solicitation, negotiation, or procurement of a fixed premium universal life insurance policy:

(1) Any statement of policy cost factors or benefits shall contain:

(a) The corresponding guaranteed policy cost factors or benefits, clearly identified;

(b) A statement explaining any nonguaranteed nature of the current premiums, interest rates, charges, or other fees applied to the policy, including the insurer's rights to alter any of these factors; and

(c) Any limitations on the crediting of interest, including identification of those portions of the policy value to which a specified interest rate shall be credited.

(2) Any illustration of the policy value shall be accompanied by the corresponding cash surrender value.

(3) Any statement regarding the crediting of a specific current interest rate shall also contain the frequency and timing by which such rate is determined.

(4) Any illustration of the policy benefits based upon nonguaranteed interest, mortality, morbidity, expense charges and loads, other current charges, current surrender or partial withdrawal charges shall be accompanied by a prominent statement indicating that these benefits are not guaranteed. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-080, filed 12/20/85.]

WAC 284-84-090 Periodic disclosure to policyowner. The policy shall provide that the policyowner will be sent, without charge, at least annually, a report which will serve to keep such policyowner advised of the status of the policy, and any riders attached, including the rights to the values and benefits. The report shall also specify the conditions, if any, that the policyowner must fulfill in order to obtain these ownerships. The end of the current report period shall be no more than three months prior to the date of the mailing of the report.

Such report shall include the following:

(1) The beginning and ending dates of the current report period;

(2) The policy value at the end of the previous report period and at the end of the current report period;

(3) The rate of interest applied to the policy value and the total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (for example, interest, mortality, expense and riders);

(4) The current death benefit at the end of the current report period on each life covered by the policy;

(5) The cash surrender value and the net cash surrender value of the policy as of the end of the current report period; and

(6) The amount of outstanding loans, if any, as of the end of the current report period; and

(7) If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-090, filed 12/20/85.]

WAC 284-84-100 Unfair practices. Pursuant to RCW 48.30.010, it shall be an unfair practice to:

(1) Contrive to set the premiums at the time of repricing so as to reduce, postpone or avoid cash values.

(2) Recoup past losses or distribute past gains when repricing the policies, when defining the current interest to be credited, or when determining mortality, morbidity or expenses to be charged.

(3) Increase the interest credited to present a more competitive rate while at the same time increasing the mortality, morbidity, expense or other charge or to adjust these and other rates in a similar manner, unless justified by actual company experience.

(4) Review less than all pricing assumptions at repricing or setting of the current credits and charges, thereby upsetting the consistent and equitable treatment of the policyholders.

(5) Add additional pricing variables to the definition of a class of insureds after issue, without the prior written approval of the commissioner.

(6) Separate one class of insureds into two or more classes after issue, without the prior written approval of the commissioner.

(7) Adjust premiums, interest credits, expenses and loads other than with respect to an entire class of insureds.

(8) Treat renewing policyholders in a manner inconsistent or inequitably with new policyholders.

(9) Have one class of insureds support, or be supported by, another class. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-100, filed 12/20/85.]

WAC 284-84-110 Filing requirements. (1) The actuarial memorandum which accompanies the policy filing shall list, among other things, the basis or modification of each table of maximum mortality charge to be used by the company; for example, male, female, and nonsmoker, smoker, etc. It shall also include sufficient numerical data and other information employed by the company to identify the standard and substandard classes of insureds.

(2) For substandard issues, the commissioner must be supplied with a sample of the appropriate policy pages completed through each type of rating used by the company; for example, percentage of standard class premium, extra premium, temporary or permanent flat charge per thousand. [Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-110, filed 12/20/85.]

Title 286 WAC

**INTERAGENCY COMMITTEE FOR
OUTDOOR RECREATION**

Chapter

286-26 Off-road vehicle funds.

Chapter 286-26 WAC

OFF-ROAD VEHICLE FUNDS

WAC

286-26-020 Definitions.
286-26-055 Funded projects.

WAC 286-26-020 Definitions. For purposes of this chapter, the following definitions shall apply:

(1) "Nonhighway vehicle" means any self-propelled vehicle when used for recreation travel on trails and nonhighway roads or for recreation cross-country travel on any one of the following or a combination thereof:

Land, water, snow, ice, marsh, swampland, and other natural terrain. Such vehicles shall include, but are not limited to, two or four-wheel drive vehicles, motorcycles, dune buggies, amphibious vehicles, ground effects or air cushion vehicles, and any other means of land transportation deriving motive power from any source other than muscle or wind.

Nonhighway vehicle does not include:

(a) Any vehicle designed primarily for travel on, over, or in the water;

(b) Snowmobiles or any military vehicles; or

(c) Any vehicle eligible for a motor vehicle fuel tax exemption or rebate under chapter 82.36 RCW for which an exemption or rebate is claimed. This exception includes, but is not limited to, farm, construction, and logging vehicles.

(2) "Off-road vehicle" (ORV) means any nonhighway vehicle when used for cross-country travel on trails or any one of the following or a combination thereof: Land, water, snow, ice, marsh, swampland and other natural terrain.

(3) "Interagency committee for outdoor recreation off-road vehicle funds" (IAC-ORV funds) means those funds deposited in the outdoor recreation account to be administered and distributed by the interagency committee in conformance with chapter 46.09 RCW, and IAC-ORV participation manuals for the planning, acquisition, development and management of ORV trails and areas.

(4) "Off-road vehicle trail" (ORV trail) means a corridor designated and maintained for public ORV recreational use which is not normally suitable for travel by conventional two-wheel drive vehicles and which is posted or designated by the managing authority of the property that the trail traverses as permitting ORV travel; this may include race courses for ORV motorcycles and four-wheeled vehicles over 40 inches width which are equipped with four-wheel drive or other characteristics such as nonslip drive trains and high clearance. Such courses will be designed to include ORV trail or area characteristics such as sharp turns, jumps, soft tread material, dips, or other obstacles found in more natural settings. Race courses designed primarily for other vehicles, such as go-karts and formula cars, constitute an inappropriate use of ORV funds.

(5) "Off-road vehicle use area" means the entire area of a parcel of land except for camping and approved buffer areas where it is posted or designated for ORV use in accordance with rules adopted by the managing authority.

(6) "Management" means the action taken in exercising control over, regulating the use of, and operation and maintenance of ORV trails and ORV areas.

(7) "Off-road vehicle advisory committee" (ORVAC) means the established committee of off-road vehicle (ORV) recreationists, including representatives of organized ORV recreational groups, to advise the director in the development of the state-wide ORV plan, the development of a project funding system, the suitability of ORV projects submitted to the interagency committee for funding, and other aspects of ORV recreation as the