

(4) These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 275-110-100.

[Statutory Authority: RCW 72.72.040, 88-15-012 (Order 2651), § 275-110-070, filed 7/8/88; 81-15-061 (Order 1682), § 275-110-070, filed 7/20/81; 80-17-004 (Order 1569), § 275-110-070, filed 11/7/80; 80-02-109 (Order 1482), § 275-110-070, filed 1/25/80.]

WAC 275-110-080 Maximum allowable reimbursement for jail facilities. The department shall limit jail facility cost reimbursement strictly to incremental costs as defined in WAC 275-110-020 and to political subdivisions listed in WAC 275-110-040. Requests for reimbursement shall be fully documented and shall include the inmate's name and all appropriate admission and release dates. Limit reimbursement to five dollars and two cents per inmate day for the period July 1, 1988, through June 30, 1989. The department shall not reimburse for costs incurred for holding persons regarding parole revocations or for holding persons involved in civil litigation. The department shall reimburse costs of providing security when inmates require hospitalization at the rate of eleven dollars and seventy-three cents per hour for the period July 1, 1988, through June 30, 1989. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 275-110-100.

[Statutory Authority: RCW 72.72.040, 88-15-012 (Order 2651), § 275-110-080, filed 7/8/88; 81-15-061 (Order 1682), § 275-110-080, filed 7/20/81; 80-17-004 (Order 1569), § 275-110-080, filed 11/7/80; 80-02-109 (Order 1482), § 275-110-080, filed 1/25/80.]

Title 284 WAC

INSURANCE COMMISSIONER

Chapters

284-02	Description of insurance commissioner's office--Organization operations and obtaining information.
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Chapter 284-02 WAC

DESCRIPTION OF INSURANCE COMMISSIONER'S OFFICE--ORGANIZATION OPERATIONS AND OBTAINING INFORMATION

WAC

284-02-010	Authority of insurance commissioner.
284-02-020	Organization and operations.
284-02-030	Obtaining service of process over foreign and alien insurers.
284-02-040	Applying for a license as agent, adjuster, broker or solicitor.
284-02-050	Application for admission as an authorized insurer, fraternal benefit society, health care service contractor, or health maintenance organization.
284-02-060	Filing complaint against company, agent, broker, solicitor, or adjuster.
284-02-070	Hearings of the insurance commissioner.
284-02-080	Publications and information available.
284-02-100	Petition for adoption, amendment, or repeal of rules.

WAC 284-02-010 Authority of insurance commissioner. (1) **The office generally.** The position of insurance commissioner was established by the legislature as an independent, elective office in 1907. The insurance commissioner's powers are set forth in chapter 48.02 RCW. To carry out the task of enforcing the insurance code the commissioner may make rules and regulations governing activities under the insurance code consistent therewith; may conduct investigations to determine whether any person has violated any provision of the code, including formal hearings; may take action against an insurance company, fraternal benefit society, health maintenance organization, and a health care service contractor by revocation or suspension of its certificate of authority or certificate of registration; may fine insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations; and may revoke or suspend the licenses of insurance agents, brokers, solicitors or adjusters or fine them. In addition, the commissioner may issue a cease and desist order pursuant to the general enforcement powers granted by RCW 48.02.080, or pursuant to that section, the commissioner may bring an action in court to enjoin violations of the insurance code.

(2) **Duties and responsibilities imposed by Title 48 RCW.**

(a) The insurance code is found at Title 48 of the Revised Code of Washington. It deals largely with the commissioner's regulation of insurance companies, insurance agents, brokers, solicitors, and adjusters.

Chapter 48.36A RCW regulates fraternal societies. Agents of fraternal benefit societies are subject to the licensing requirements of chapter 48.17 RCW. Fraternal benefit societies are subject to the provisions of chapter 48.30 RCW relating to unfair trade practices, and RCW 48.36A.360 sets forth the penalties for violation of the fraternal benefit society chapter.

Chapter 48.41 RCW, entitled "Health Insurance Coverage Access Act," provides a mechanism to assure the availability of comprehensive health insurance coverage to residents of Washington who are denied adequate health insurance coverage.

Chapter 48.44 RCW regulates health care service contractors and chapter 48.46 RCW regulates health maintenance organizations, as defined therein. The regulatory powers of the insurance commissioner over health care service contractors and health maintenance organizations are similar to those over commercial insurers.

(b) The insurance code contains a number of substantive provisions which relate to the rights of policyholders in general and which are enforced for their benefit by the insurance commissioner. Those, for the most part, are contained in chapter 48.18 RCW, which is entitled "The insurance contract," and chapter 48.30 RCW, entitled "Unfair practices and frauds." Additional substantive provisions are contained in chapters of the insurance code dealing with specific lines of insurance. For example, certain standard provisions are required to be placed in a disability insurance contract (chapter 48.20 RCW). Similarly, substantive provisions appear in chapter 48.21 RCW, entitled "Group and blanket disability insurance," chapter 48.23 RCW, entitled "Life insurance and annuities," chapter 48.24 RCW, entitled "Group life and annuities," chapter 48.22 RCW, entitled "Casualty insurance," chapter 48.34 RCW, entitled "Credit life insurance and credit accident and health insurance," chapter 48.56 RCW, entitled "Insurance Premium Finance Company Act," chapter 48.66 RCW, entitled "Medicare Supplemental Health Insurance Act," and chapter 48.84 RCW, entitled "Long-term Care Insurance Act."

(3) **Additional duties of the insurance commissioner.** The state insurance commissioner has been assigned the special duty of preparing annuity tables for calculation of the industrial insurance reserve fund (RCW 51.44-.070). The commissioner must also publish for use of the state courts and appraisers, tables showing the average expectancy of life, and values of annuities and life and term estates (RCW 48.02.160).

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-010, filed 11/18/88; Order R-68-6, § 284-02-010, filed 8/23/68, effective 9/23/68.]

WAC 284-02-020 Organization and operations. The insurance commissioner is the head of an agency generally referred to as the insurance commissioner's office, and as such is its chief administrative officer. The commissioner's office consists of three major divisions: Administrative, company supervision, and consumer protection. The commissioner may appoint a chief deputy commissioner who has the same powers as are granted to the commissioner. The commissioner may appoint additional deputy commissioners for such purposes as he may designate (RCW 48.02.090).

(1) Administrative division.

(a) Licensing and insurance education. Licenses are issued to individuals, partnerships, and corporations to

act as insurance agents, brokers, solicitors, adjusters, and premium finance companies. Insurance education and licensing renewal requirements are the responsibility of this section and the content of continuing education programs is supervised by it.

(b) Taxes, fees, and accounting responsibilities. Taxes and fees imposed by the insurance code are collected and processed by the commissioner.

(i) Both domestic and foreign insurers are taxed on gross premium, pursuant to RCW 48.14.020. Fraternal benefit societies and title insurers are not taxed, as provided in chapters 48.36A and 48.14 RCW, respectively. Surplus line insurance is taxed pursuant to the provisions of RCW 48.15.120. Health care service contractors and health maintenance organizations are not taxed. The current rate of taxation is stated at RCW 48.14.020. Under the retaliatory provisions of RCW 48.14.040, if the laws of another state or country impose any taxes, fees, or other obligations in excess of the rate charged a Washington domestic insurer, a like rate or obligation may be imposed by the commissioner.

(ii) Fees paid by insurers (RCW 48.14.010), health care service contractors (RCW 48.44.040), health maintenance organizations (RCW 48.46.140), and agents, brokers, solicitors, and adjusters (chapter 48.17 RCW) are also collected by the administrative division.

(2) Company supervision division. The deputy commissioner for company supervision supervises admission of all insurers and examines their financial condition and adequacy of their forms and rates.

(a) Admissions of companies. Admission of insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations is administered by the company supervision division. Additionally the commissioner, through this division, approves proxy statements of domestic stock companies (RCW 48.08.090), supervises the insider trading law (RCW 48.08.100 through 48.08.170) and control of domestic insurers (chapter 48.31A RCW), registers liability risk retention groups (chapter 48.92 RCW), handles certification of official documents, and approves company names.

(b) Examinations (financial and market conduct). Examination of authorized insurers is regulated by chapter 48.03 RCW. Each domestic insurer and each rating organization and examining bureau licensed in this state is examined as often as the commissioner deems advisable but at least once in every five years. Examinations of advisory organizations and underwriting or reinsurance groups are performed as often as the commissioner deems appropriate. The commissioner may accept the last recent examination of nondomestic insurers. Examiners analyze the insurers' various accounts, records, and files to determine the financial condition of the company and to ascertain whether business is being conducted in conformity with the insurance code and its regulations. Reports of examinations are furnished to the organization, which then has ten days to request a hearing to consider objections to the report. Once the hearing has been held and modifications deemed necessary have

been made, the report may then be made public; although the commissioner may withhold the report if it is in the public interest to do so (RCW 48.03.050).

(c) Rates and forms review. The company supervision division approves forms for policies, applications, policy riders, and endorsements (RCW 48.18.110), and may disapprove such forms pursuant to grounds set forth in RCW 48.18.110. Rates for property, surety, and casualty insurance (chapter 48.19 RCW), and title insurance (RCW 48.29.140) are also approved by this division. Rates may not be excessive, inadequate, or unfairly discriminatory (RCW 28.19.020). Additionally, the insurance commissioner may disapprove rates for disability insurance (RCW 48.18.110), for credit insurance (RCW 48.34.100), and long-term care insurance (RCW 48.84.030), when the rates charged are not reasonable in relation to the benefits conferred. Prima facie acceptable rates have been established for credit insurance (WAC 284-34-010). Contract forms for health care service contractors may be disapproved pursuant to RCW 48.44.020 and health care agreements for health maintenance organizations may be disapproved pursuant to RCW 48.46.060.

(3) Consumer protection division. The deputies in the consumer protection division act as consumer advocates by rendering assistance to consumers who make complaints against insurers. In addition, this division drafts changes to, and interprets issues relative to, the insurance code and its regulations, performs special consumer advocacy functions relating to education of senior citizens, and investigates licensees to insure compliance with the insurance laws and rules of this state. This division has primary responsibility for the conduct of hearings, the procedural matters preliminary thereto, and the preservation of hearing records.

(a) Consumer assistance. Code compliance officers, currently located in offices of the insurance commissioner in Olympia, Seattle, Spokane, Tacoma and Yakima, handle written and oral inquiries and complaints from policyholders and claimants. Assistance is rendered by the commissioner pursuant to authority to enforce the various provisions of the insurance code, including RCW 48.02.060, 48.02.080, and 48.02.160, and based on authority to take disciplinary action against an insurance company and other licensees. While the consumer protection division provides assistance to members of the public and tries to resolve complaints concerning insurers and licensees, some matters will involve disputed facts or laws and will have to be resolved in court or arbitration proceedings. The commissioner is not a substitute for the courts.

(b) Regulations and statutes. The consumer protection division evaluates existing statutes and rules, proposes additional legislation, drafts new insurance regulations, and assists in the enforcement of laws and regulations.

(c) Special programs. To help senior consumers find their way through the sometimes confusing maze of state, federal, and private insurance options available to citizens over age sixty, the insurance commissioner sponsors the senior health insurance benefit advisors (SHIBA) program. SHIBA volunteers throughout the

state act as unpaid advisors to other seniors in the community, answer basic health insurance questions, and refer people to the proper governmental agency to find solutions to their insurance problems.

(d) Investigation and enforcement. Members of the consumer protection division investigate activities of licensees and companies to determine whether corrective action or disciplinary proceedings are needed, and institute proceedings leading to fines, license revocations or suspensions, as appropriate.

(4) Legal assistance from the attorney general. Assistant attorneys general are assigned as needed to the insurance commissioner's office to render legal advice, to represent the commissioner in disciplinary hearings and court cases, and to assist in the drafting of legislation and regulations.

(5) Insurance advisory examining board. An insurance advisory examining board, made up of seven Washington insurance agents or brokers who have been licensed in this state for at least five years, has the power to recommend general policy concerning the scope, content, procedure, and conduct of examinations to be given for licenses as insurance agents, brokers, or solicitors (RCW 48.17.135).

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-020, filed 11/18/88; Order R-68-6, § 284-02-020, filed 8/23/68, effective 9/23/68.]

WAC 284-02-030 Obtaining service of process over foreign and alien insurers. Although domestic insurers are served with legal process personally, the insurance commissioner is the party on whom service of process should be made on all foreign and alien insurers, whether authorized to transact business in this state or not. The exact procedures are set forth in the applicable statutes. Service of process against authorized foreign and alien insurers, other than surplus line insurers, must be made pursuant to RCW 48.05.200 and 48.05.210. RCW 48.05.220 specifies the proper venue for such actions. Service of process against surplus line insurers can be made on the commissioner, pursuant to the procedures set forth in RCW 48.05.215 and 48.15.150. (A surplus lines insurer markets coverage which cannot be procured in the ordinary market from authorized insurers.) Service of process against other unauthorized insurers may be made on the commissioner, pursuant to the procedures set forth in RCW 48.05.215.

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-030, filed 11/18/88; Order R-68-6, § 284-02-030, filed 8/23/68, effective 9/23/68.]

WAC 284-02-040 Applying for a license as agent, adjuster, broker or solicitor. Licensing requirements and instructions for obtaining a license as an insurance agent, adjuster, broker or solicitor may be obtained from the licensing section in Olympia.

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-040, filed 11/18/88; Order R-68-6, § 284-02-040, filed 8/23/68, effective 9/23/68.]

WAC 284-02-050 Application for admission as an authorized insurer, fraternal benefit society, health care

service contractor, or health maintenance organization. A check list of documents required for an application for admission is available from the company supervision deputy. The statutory requirements are contained in chapter 48.05 RCW (all insurance companies); chapter 48.06 RCW (domestic companies); chapter 48.07 RCW (domestic stock companies); chapter 48.09 RCW (mutual companies); chapter 48.10 RCW (reciprocal companies); chapter 48.36A RCW (fraternal benefit societies); chapter 48.44 RCW (health care service contractors), and chapter 48.46 RCW (health maintenance organizations). Capital and surplus requirements for stock insurance companies are contained in RCW 48.05.340.

[Statutory Authority: RCW 48.02.060 (3)(a). 88-23-079 (Order R 88-10), § 284-02-050, filed 11/18/88; Order R-68-6, § 284-02-050, filed 8/23/68, effective 9/23/68.]

WAC 284-02-060 Filing complaint against company, agent, broker, solicitor, or adjuster. A grievance against an insurance company, fraternal benefit society, health care service contractor, health maintenance organization, agent, broker, solicitor, or adjuster may be filed with the insurance commissioner. To do so the insurance commissioner should be supplied with as many facts as possible to assist in the investigation of the complaint. This should include the correct name of the insurance company, the policy and/or claim number, the name of the agent, broker, solicitor, or adjuster, the date of loss, and a complete explanation of the loss or other problem. A form to be used in making a complaint may be requested by telephone from one of the insurance commissioner's offices. Use of such form may be helpful in organizing the information, but is not required.

[Statutory Authority: RCW 48.02.060 (3)(a). 88-23-079 (Order R 88-10), § 284-02-060, filed 11/18/88; Order R-68-6, § 284-02-060, filed 8/23/68, effective 9/23/68.]

WAC 284-02-070 Hearings of the insurance commissioner. (1) Hearings of the insurance commissioner's office are conducted according to chapter 48.04 RCW and the Administrative Procedure Act. (Until July 1, 1989, the Administrative Procedure Act is found at chapter 34.04 RCW; thereafter the Administrative Procedure Act will be found at chapter 34.05 RCW). Two types of hearings are conducted: Rule-making hearings and adjudicative proceedings or contested case hearings, the latter including appeals from disciplinary actions taken by the commissioner. Under RCW 48.04.010 the commissioner is required to hold a hearing upon demand by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under the code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing. Requests for hearings must be made in writing, must specify how the person making the demand has been aggrieved by the commissioner, and the demand must specify the

grounds to be relied upon as the basis for the relief sought.

(2) Contested cases or adjudicative proceedings.

(a) Provisions specifically relating to disciplinary action taken against insurance agents, brokers, solicitors, or adjusters are contained in RCW 48.17.530, 48.17.540, 48.17.550, and 48.17.560. Provisions applicable to other adjudicative proceedings are contained in chapter 48.04 RCW and the Administrative Procedure Act. The uniform rules of practice and procedure which appear in Title 10 of the Washington Administrative Code, govern procedures not contained in the statutes. The grounds for disciplinary action against insurance agents, brokers, solicitors, and adjusters are contained in RCW 48.17.530; grounds for similar action against insurance companies are contained in RCW 48.05.140, grounds for actions against fraternal benefit societies are found at RCW 48.36A.300 (domestic) and RCW 48.36A.310 (foreign), grounds for action against health care service contractors are contained in RCW 48.44.160, and grounds for action against health maintenance organizations are contained in RCW 48.46.130. These statutes provide that the insurance commissioner may suspend or revoke a licensee's license, or the certificate of authority or registration of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization. In addition, the commissioner may, generally levy fines against those licensees and organizations.

(b) Adjudicative proceedings or contested case hearings of the insurance commissioner are informal in nature, and formal rules of pleading and evidence are not required. The commissioner may delegate to any deputy the authority to hear and determine the matter pursuant to RCW 48.02.100 or may utilize the services of an administrative law judge in accordance with chapter 34.12 RCW and the Administrative Procedure Act. The hearing will be recorded by any method chosen by the presiding officer. Except as required by law, the commissioner's office is not required, at its expense, to prepare a transcript. Any party, at the party's expense, may cause a reporter approved by the commissioner to prepare a transcript from the agency's record, or cause additional recordings to be made during the hearing if, in the opinion of the presiding officer, the making of the additional recording does not cause distraction or disruption. If appeal from the commissioner's order is made to the superior court, the recording of the hearing will be transcribed, and certified to the court. The commissioner allows any person affected by the hearing to be present during the giving of all testimony and will allow the aggrieved person a reasonable opportunity to inspect all documentary evidence, to examine witnesses and to present evidence. Any person heard must make full disclosure of the facts pertinent to the inquiry.

(c) Unless a person aggrieved by an order of the commissioner demands a hearing thereon within ninety days after receiving notice of such order, or in the case of licensees, within ninety days after the commissioner has mailed the order to the licensee at the most recent address shown in the commissioner's licensing records, the

right to such a hearing shall conclusively be deemed to have been waived (RCW 48.04.010(3)).

(d) The commissioner must hold any hearing demanded within thirty days after receipt of the demand, unless postponed by mutual consent.

(3) **Rule-making hearings.** Rule-making hearings of the insurance commissioner are conducted pursuant to the Administrative Procedure Act, chapter 34.08 RCW (the State Register Act), and chapter 48.04 RCW. Under applicable law all interested parties must be afforded an opportunity to express their views concerning a proposed regulation of the insurance commissioner's office, either orally or in writing. Notice of intention of the insurance commissioner to adopt a proposed rule or regulation is published in the state register, is sent to anyone who has requested notice in advance, and to persons whom the commissioner determines would be particularly interested in the proceeding.

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-070, filed 11/18/88; Order R-68-6, § 284-02-070, filed 8/23/68, effective 9/23/68.]

WAC 284-02-080 Publications and information available. (1) **Insurance code.** The insurance commissioner publishes a copy of Title 48 RCW, pursuant to authority of RCW 48.02.180. Copies of the administrative rules and regulations of the insurance commissioner (Title 284 WAC) are available in pamphlet form. Each may be purchased from the commissioner's Olympia office. In addition, Titles 48 RCW and 284 WAC are available in any law library, as well as in most general libraries.

(2) **List of authorized insurers.** The insurance commissioner publishes periodically a list of all insurance companies authorized to do business in this state. Such lists are available on request from the insurance commissioner's office. An insurer not authorized to do business in Washington is forbidden by law from soliciting business in this state (RCW 48.15.020).

(3) **Annual report.** The insurance commissioner publishes an annual report, as required by RCW 48.02.170, a copy of which is available on request. Generally, the annual report contains a list of all insurers authorized to transact insurance in this state, showing the insurer's name, location, and kinds of insurance transacted. It also tabulates abstracts of the annual statements of all authorized insurers, and contains a summary of the operations of the insurance commissioner's office.

(4) **Policy forms and rates.** Rates of insurance companies and all policy forms required to be filed and/or approved by the insurance commissioner's office are on file in that office and are public records.

(5) **Examination reports, annual reports.** Reports of examination and annual reports of insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations are on file in the insurance commissioner's office and are open for public inspection.

(6) **Official actions of the insurance commissioner.** As required by the Administrative Procedure Act, actions

taken by the insurance commissioner's office relating to adoption of rules or the discipline of insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, insurance agents, brokers, solicitors, or adjusters are on file in the commissioner's Olympia office and are a matter of public record.

(7) **Deposits of insurers.** Records of deposits of insurers, required by chapter 48.16 RCW and other sections of the insurance code, are on file in the insurance commissioner's office.

(8) **Articles of incorporation, bylaws of insurers.** All insurers are required to file their articles of incorporation and bylaws, and any amendments thereto, with the insurance commissioner's office. These are open for public inspection in the insurance commissioner's office.

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-080, filed 11/18/88; Order R-68-6, § 284-02-080, filed 8/23/68, effective 9/23/68.]

WAC 284-02-100 Petition for adoption, amendment, or repeal of rules. (1) As required by the Administrative Procedure Act, any interested person may petition the commissioner requesting the adoption, amendment, or repeal of any rule. The petition shall be in writing, dated and signed by the petitioner. Each petition shall include the following information:

(a) The name and address of the person requesting the action, and, if pertinent, the background and identity of the petitioner and the interest of the petitioner in the subject matter of the rule;

(b) The full text of any proposed new or amendatory rule and the citation and caption of any existing rule to be amended or repealed;

(c) A narrative explaining the purpose and scope of any proposed new or amendatory rule including a statement generally describing how the rule is to be implemented, and giving reasons for the proposed action, accompanied by necessary or pertinent data in support of thereof; and

(d) Statements from other persons in support of the action petitioned are encouraged.

(2) Within thirty days after submission of a petition to adopt, amend, or repeal any rule, the commissioner shall formally consider the petition and all supporting documentation presented. The commissioner shall within thirty days after consideration either deny the petition in writing to the person requesting the action, stating the reasons therefore, or shall initiate rule-making proceedings in accordance with the Administrative Procedure Act.

(3) If the commissioner determines it to be in the interest of the public, the commissioner may order a hearing for the further consideration and discussion of the requested adoption, amendment, or repeal of any rule.

[Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-100, filed 11/18/88.]

Chapter 284-07 WAC
REQUIREMENTS AS TO COMPANY REPORTS
AND ANNUAL STATEMENTS

WAC

284-07-010	Special liability insurance report required annually.
284-07-014	Form A for loss and expense exhibit.
284-07-024	Form B for reporting paid and unpaid losses.
284-07-026	Form C for reporting closed and open claims.

WAC 284-07-010 Special liability insurance report required annually. (1) Pursuant to RCW 48.05.380, each insurer authorized to write property and casualty insurance in the state of Washington shall record and report its Washington state loss and expense experience and other data, as required by RCW 48.05.390, on Form A, Form B, and Form C, as set forth in WAC 284-07-014, 284-07-024, and 284-07-026, respectively.

(2) Each such insurer shall complete the forms in accordance with the definitions and instructions on the forms.

(3) Each such insurer shall submit these reports to the insurance commissioner annually. Reports covering the period ending December 31 of each year must be submitted no later than May 1 of the following year.

[Statutory Authority: RCW 48.02.060 and 48.05.380. 89-02-016 (Order R 88-16), § 284-07-010, filed 12/28/88. Statutory Authority: RCW 48.05.380. 87-05-011 (Order R 87-2), § 284-07-010, filed 2/11/87.]

WAC 284-07-014 Form A for loss and expense exhibit.

STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

Form A

State of Washington Loss and Expense Exhibit for Calendar Year _____

COMPANY NAME: _____ NAIC GROUP CODE: _____
CONTACT PERSON: _____ TITLE: _____ NAIC COMPANY CODE: _____
MAILING ADDRESS: _____
CITY/STATE/ZIP: _____ TELEPHONE: _____

PREMIUMS, LOSSES EXPENSES AND NET INCOME (Amounts in thousands of dollars.)	MEDICAL MALPRACTICE				PRODUCTS LIABILITY 5	ATTORNEYS MALPRACTICE 6	ARCHITECTS & ENGINEERS MALPRACTICE 7	MUNICIPAL LIABILITY 8	DAY CARE CENTER LIABILITY 9
	PHYSICIANS & SURGEONS 1	HOSPITALS 2	OTHER HEALTH CARE PROFESSIONS 3	OTHER HEALTH CARE FACILITIES 4					
1 Direct Premiums Written									
2 Direct Premiums Earned									
3a Direct Losses Paid									
3b Change in Direct Case Reserves									
3c Change in Direct IBNR Reserve									
3d Direct Losses Incurred: 3a+3b+3c									
4 Direct Loss Adjustment Expense Incurred									
5 Direct Commission and Brokerage Incurred									
6 Other Acquisition, Field Supervision and Collection Expenses Incurred									
7 General Expenses Incurred									
8 Taxes, Licenses and Fees Incurred									
9 Total Expenses Incurred: 4+5+6+7+8									
10 Net Investment Gain or Loss and Other Income (including net realized capital gain or loss)									
11 Dividends to Policyholders									
12 Net income before federal and foreign income taxes: (2+10) - (3d+9+11)									

Enter premium, loss and expense data allocable to Washington insureds only. The format of this form is identical to the Insurance Expense Exhibit, Part IIA, filed with the statutory annual statement, except that all items must be adjusted to a direct basis and components of incurred losses must be shown (Lines 3a, 3b and 3c). Otherwise, the same adjustments, assumptions and formulas used to complete the Insurance Expense Exhibit should be used for this exhibit. The Medical Malpractice sublines should be as defined for Supplement A to Schedule T of the statutory annual statement. The Products Liability subline should be as defined for the Products Liability Insurance Supplement to the statutory annual statement. The other sublines should be defined using appropriate statistical coding for policies with specific premium charges for such coverages or with an indivisible premium for which at least 50% of the loss coverage is for one of these liability sublines. Municipal Liability refers to coverage for all classes of local government entities.

"Direct Premium" includes additional premium billings, return premiums, audit and retrospective adjustments but does not include reinsurance transactions. "Direct Losses" includes salvage, subrogation and other recoveries but not reinsurance losses ceded or assumed.

"Losses Incurred" must be calculated as losses paid plus the change in losses unpaid (including incurred but not reported claims) from the beginning of the calendar year to the end of the year.

Attach a brief memorandum explaining how these items have been allocated to Washington.

This exhibit is required by RCW 48.05.380 and .390. It must be filed not later than May 1 for the preceding calendar year.

Send completed exhibit to: Property / Casualty Actuary, Office of Insurance Commissioner, Insurance Building, Olympia, WA 98504.

[Statutory Authority: RCW 48.02.060 and 48.05.380. 89-02-016 (Order R 88-16), § 284-07-014, filed 12/28/88. Statutory Authority: RCW 48-05.380. 87-05-011 (Order R 87-2), § 284-07-014, filed 2/11/87.]

WAC 284-07-024 Form B for reporting paid and unpaid losses.

STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

Form B

State of Washington Report Year Exhibit as of December 31, _____

PAID AND UNPAID LOSSES

COMPANY NAME _____ NAIC GROUP CODE: _____
 CONTACT PERSON: _____ TITLE: _____ NAIC COMPANY CODE: _____
 MAILING ADDRESS: _____
 CITY/STATE/ZIP: _____ TELEPHONE: _____

YEAR IN WHICH CLAIM WAS FIRST REPORTED TO INSURER		MEDICAL MALPRACTICE				PRODUCTS LIABILITY 5	ATTORNEYS MALPRACTICE 6	ARCHITECTS & ENGINEERS MALPRACTICE 7	MUNICIPAL LIABILITY 8	DAY CARE CENTER LIABILITY 9
		PHYSICIANS & SURGEONS 1	HOSPITALS 2	OTHER HEALTH CARE PROFESSIONS 3	OTHER HEALTH CARE FACILITIES 4					
	Paid									
	Unpaid									
	Paid									
	Unpaid									
	Paid									
	Unpaid									
	Paid									
	Unpaid									
	Paid									
	Unpaid									
	Paid									
	Unpaid									
	Paid									
	Unpaid									

In the left column, enter the last nine calendar years, from earliest to latest. Losses are to be sorted by the calendar year in which each claim was first reported to the insurer. Report cumulative payments and outstanding losses as of December 31 of the latest year. Please inspect the reported amounts for consistency with the amounts shown on the previous year's report, in which losses were evaluated as of the previous year-end.
 Enter paid and unpaid loss amounts attributable to Washington insureds only. Report amounts in thousands of dollars. The Medical Malpractice sublines should be as defined for Supplement A to Schedule T of the statutory annual statement. The Products Liability subline should be as defined for the Products Liability Insurance Supplement to the statutory annual statement. The other sublines should be defined using appropriate statistical coding for such coverages. Municipal Liability refers to coverage for all classes of local government entities.
 Paid and unpaid losses are to be reported on a direct basis, including salvage, subrogation and other recoveries but not reinsurance losses ceded or assumed. Reserves for incurred but not reported losses should be excluded.
 This exhibit is required by RCW 48.05.390 and .390. It must be filed not later than May 1 for losses evaluated as of December 31 of the preceding year.
 Send completed exhibit to: Property/Casualty Actuary, Office of Insurance Commissioner, Insurance Building, Olympia, WA 98504.

INS (9/88) - 1438-3

[Statutory Authority: RCW 48.02.060 and 48.05.380. 89-02-016 (Order R 88-16), § 284-07-024, filed 12/28/88. Statutory Authority: RCW 48.05.380. 87-05-011 (Order R 87-2), § 284-07-024, filed 2/11/87.]

WAC 284-07-026 Form C for reporting closed and open claims.

STATE OF WASHINGTON OFFICE OF INSURANCE COMMISSIONER

Form C

State of Washington Report Year Exhibit as of December 31, _____

CLOSED AND OPEN CLAIMS

COMPANY NAME: _____ NAIC GROUP CODE: _____

CONTACT PERSON: _____ TITLE: _____ NAIC COMPANY CODE: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____ TELEPHONE: _____

Table with 10 columns: Year in which claim was first reported to insurer, Medical Malpractice (Physicians & Surgeons, Hospitals, Other Health Care Professions, Other Health Care Facilities), Products Liability, Attorneys Malpractice, Architects & Engineers Malpractice, Municipal Liability, Day Care Center Liability. Rows include categories like 'Closed with Payment', 'Closed without Payment', and 'Open'.

In the left column, enter the last nine calendar years, from earliest to latest. Claims are to be sorted by the calendar year in which each claim was first reported to the insurer. Report cumulative closed claim counts and open claim counts as of December 31 of the latest year. Please inspect the reported counts for consistency with the counts shown on the previous year's report. Except in unusual circumstances, the total number of reported claims for each year should be the same as shown on the previous year's report.

Enter the number of claims attributable to Washington insureds only. The Medical Malpractice sublines should be as defined for Supplement A to Schedule T of the statutory annual statement. The Products Liability subline should be as defined for the Products Liability Insurance Supplement to the statutory annual statement. The other sublines should be defined using appropriate statistical coding for such coverages. Municipal Liability refers to coverage for all classes of local government entities.

All claim counts are to be reported on a direct basis.

This exhibit is required by RCW 48.05.380 and .390. It must be filed not later than May 1 for claim counts evaluated as of December 31 of the preceding year.

Send completed exhibit to: Property/Casualty Actuary, Office of Insurance Commissioner, Insurance Building, Olympia, WA 98504.

INS (9-88) -1438-



[Statutory Authority: RCW 48.02.060 and 48.05.380. 89-02-016 (Order R 88-16), § 284-07-026, filed 12/28/88.]

Chapter 284-12 WAC AGENTS, BROKERS AND ADJUSTERS

WAC

284-12-080 Requirements for separate accounts.

284-12-110 Identification of agent or solicitor to prospective insured.

WAC 284-12-080 Requirements for separate accounts. (1) The purpose of this section is to effectuate RCW 48.17.600 and 48.17.480 with respect to the separation and accounting of premium funds by agents, brokers, solicitors, general agents and surplus line brokers, hereinafter called "producers." Pursuant to RCW 48.30.010, the commissioner has found and hereby defines it to be an unfair practice for any producer, except as allowed by statute, to conduct insurance business without complying with the requirements of RCW 48.17.600 and this section. As provided in RCW 48.17.600, agents

for title insurance companies or insurance brokers whose average daily balance for premiums received on behalf of insureds in the state of Washington equals or exceeds one million dollars, are exempt from subsections (1) through (5) of this section, except with respect to premiums and return premiums received in another licensing capacity.

(2) All funds representing premiums and return premiums received on Washington business by a producer in his or her fiduciary capacity on or after January 1, 1987, shall be deposited in one or more identifiable separate accounts which may be interest bearing.

(a) A producer may deposit no funds other than premiums and return premiums to the separate account except as follows:

(i) Funds reasonably sufficient to pay bank charges;

(ii) Funds a producer may deem prudent for advancing premiums, or establishing reserves for the paying of return premiums; and

(iii) Funds for contingencies as may arise in the business of receiving and transmitting premiums or return premiums.

(b) A producer may commingle Washington premiums and return premiums with those produced in other states, but there shall be no commingling of any funds which would not be permitted by this section.

(3)(a) The separate account funds may be:

(i) Deposited in a checking account, demand account, or a savings account in a bank, national banking association, savings and loan association, mutual savings bank, stock savings bank, credit union, or trust company located in the state of Washington. Such an account must be insured by an entity of the federal government; or

(ii) Invested in United States government bonds and treasury certificates or other obligations for which the full faith and credit of the United States government is pledged for payment of principal and interest, repurchase agreements collateralized by securities issued by the United States government, and bankers acceptances. Insurers may, of course, restrict investments of separate account funds by their agent.

(b) A nonresident licensee, or a resident producer with affiliated operations under common ownership in two or more states, may utilize comparable accounts in another state provided such accounts otherwise meet the requirements of RCW 48.17.600 and this rule, and are accessible to the commissioner for purposes of examination or audit at the expense of the producer.

(4)(a) The entire premium received (including a surplus lines premium tax if paid by the insured) must be deposited into the separate account. Such funds shall be paid promptly to the insurer or to another producer entitled thereto, in accordance with the terms of any applicable agreement between the parties.

(b) Return premiums received by a producer and the producer's share of any premiums required to be refunded, must be deposited promptly to the separate account. Such funds shall be paid promptly to the insured or person entitled thereto.

(5)(a) Where a producer receives a premium payment in the form of an instrument, such as a check, which is made payable to an insurer, general agent or surplus line broker, the producer may forward such instrument directly to the payee if that can be done without endorsement or alteration. In such a case, the producer's separate account is not involved because the producer has not "received" any funds.

(b) If the producer receives a premium payment in the form of cash or an instrument requiring endorsement by the producer, such premium must be deposited into the producer's separate account, unless the insurer entitled to such funds has established other procedures by written direction to a producer who is its appointed agent, which procedures:

(i) Recognize that such agent is receiving premiums directly on behalf of the insurer; and

(ii) Direct the producer to give adequate receipts on behalf of the insurer; and

(iii) Require deposit of the proceeds into the insurer's own account or elsewhere as permitted by the insurer's direction.

Thus, for example, an insurer may utilize the services of a licensed agent, known in the industry as a "captive agent," in the sale of its insurance and in the operation of its places of business, and directly receive payments intended for it without such payments being deposited into and accounted for through the licensed agent's separate account. In such cases, for purposes of this rule, the insurer, as distinguished from the agent, is actually "receiving" the funds and is immediately responsible therefor.

(c) When a producer receives premiums in the capacity of a surplus line broker, licensed pursuant to chapter 48.15 RCW, after a binder or other written evidence of insurance has been issued to the insured, subject to the express written direction of the insurer involved, such premiums may be removed from the separate account.

(6) The commissioner recognizes the practical problems of accounting for the small amounts of interest involved spread over a large number of insurers and insureds. Therefore, absent any agreement between the producer and the insured or insurer to the contrary, interest earned on the deposits held in the separate account may be retained by the producer and used to offset bank charges, establish reserves, pay return premiums, or for any of the purposes listed in subsection (2) of this section, or the interest may be removed to the operating account.

(7) A producer shall establish and maintain records and an appropriate accounting system for all premiums and return premiums received by the producer, and shall make such records available for inspection by the commissioner during regular business hours upon demand during the five years immediately after the date of the transaction.

(8) The accounting system used must effectively isolate the separate account from any operating accounts. All recordkeeping systems, whether manual or electronic must provide an audit trail so that details underlying the summary data, such as invoices, checks, and statements, may be identified and made available on request. Such a system must provide the means to trace any transaction back to its original source or forward to final entry, such as is accomplished by a conventional double-entry bookkeeping system. When automatic data processing systems are used, a description of the system must be available for review by the commissioner. A balance forward system (as in an ordinary checking account) is not acceptable.

(9)(a) A producer that is a firm or corporation may utilize one separate account for the funds received by its affiliated persons operating under its license, and such affiliated persons may deposit the funds they receive in such capacity directly into the separate account of their firm or corporation.

(b) Funds received by a solicitor may be deposited into and accounted for through the separate account of the agent or broker represented by the solicitor.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-17-117 (Order R 88-8), § 284-12-080, filed 8/24/88; 87-03-055 (Order R 87-1), § 284-12-080, filed 1/21/87.]

WAC 284-12-110 Identification of agent or solicitor to prospective insured. It shall be an unfair practice for an agent or solicitor initiating a sales presentation away from his or her office to fail to inform the prospective purchaser, prior to commencing the sales presentation, that the agent or solicitor is acting as an insurance agent or solicitor, and to fail thereafter to inform the prospective purchaser of the full name of the insurance company whose product the agent or solicitor offers to the buyer. This rule shall apply to all lines of insurance and to all coverage solicited in this state including coverage under a group policy delivered in another state, whether or not membership in the group is also being solicited.

[Statutory Authority: RCW 48.02.060. 88-24-053 (Order R 88-12), § 284-12-110, filed 12/7/88.]

Chapter 284-13 WAC

ASSETS--LIABILITIES--INVESTMENTS AND REINSURANCE

WAC

LIFE REINSURANCE AGREEMENTS

284-13-110	Purpose.
284-13-120	Scope.
284-13-130	Accounting requirements.
284-13-140	Written agreements.
284-13-150	Existing agreements.

LIFE REINSURANCE AGREEMENTS

WAC 284-13-110 Purpose. The purpose of WAC 284-13-110 through 284-13-150, is to set standards for life reinsurance agreements in order that the financial statements of life insurers properly reflect the financial condition of the ceding insurer and properly credit reserves.

[Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-110, filed 4/20/87.]

WAC 284-13-120 Scope. WAC 284-13-110 through 284-13-150 shall apply to all domestic life insurers and to all other life insurers authorized to do business in the state of Washington who are not subject to a substantially similar regulation in their domiciliary state.

[Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-120, filed 4/20/87.]

WAC 284-13-130 Accounting requirements. (1) No life insurer subject to this chapter shall, for reinsurance ceded, reduce any liability or establish or increase any asset in any financial statement filed with the commissioner if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(a) The primary effect of the reinsurance agreement is to transfer deficiency reserves or excess interest reserves to the books of the reinsurer for a "risk charge" and the agreement does not provide for significant participation by the reinsurer in one or more of the following risks: Lapse, surrender, mortality, morbidity, or investment;

(b) The reserve credit taken by the ceding insurer is not in compliance with the insurance code or its regulations, including actuarial interpretations or standards adopted by the commissioner;

(c) The reserve credit taken by the ceding insurer is greater than the underlying reserve of the ceding company supporting the policy obligations transferred under the reinsurance agreement;

(d) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against prior years' losses nor payment by the ceding insurer of an amount equal to prior years' losses upon voluntary termination of in-force reinsurance by that ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience;

(e) The ceding insurer can be deprived of surplus at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums shall not be considered to be such a deprivation of surplus;

(f) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

(g) No cash payment is due from the reinsurer, throughout the lifetime of the reinsurance agreement, with all settlements prior to the termination date of the agreement made only in a "reinsurance account," and no funds in such account are available for the payment of benefits; or

(h) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income reasonably expected from the reinsured policies.

(2) Accounting procedures precluded by this chapter shall not be construed as a limitation on the authority of the commissioner to disapprove other procedures in accordance with RCW 48.12.030.

(3) Notwithstanding any other provision of this section, a life insurer subject to this chapter may, with the prior approval of the commissioner take such reserve credit as the commissioner may deem consistent with the insurance code or its regulations, including actuarial interpretations or standards adopted by the commissioner.

[Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-130, filed 4/20/87.]

WAC 284-13-140 Written agreements. (1) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any

asset in any financial statement filed with the commissioner, unless the agreement, amendment, or a letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

(2) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

[Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-140, filed 4/20/87.]

WAC 284-13-150 Existing agreements. Life insurers subject to this chapter may continue to reduce liabilities or establish assets in financial statements filed with the commissioner for reinsurance ceded under unacceptable types of reinsurance agreements described in WAC 284-13-130, provided:

(1) The agreements were executed and in force prior to the effective date of this chapter;

(2) No new business is ceded under the agreements after the effective date of this chapter;

(3) The reduction of the liability reaches, or the asset established for the reinsurance ceded is reduced to, zero by December 31, 1989, or such later date approved by the commissioner as a result of an application made by the ceding insurer prior to December 31, 1987;

(4) The reduction of the liability or the establishment of the asset is otherwise permissible under all other applicable provisions of the insurance code or its regulations, including actuarial interpretations or standards adopted by the commissioner; and

(5) The commissioner is notified, within ninety days following the effective date of this chapter, of the existence of such reinsurance agreements and all corresponding credits taken in the ceding insurer's 1986 annual statement.

[Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-150, filed 4/20/87.]

Chapter 284-17 WAC

LICENSING REQUIREMENTS AND PROCEDURES

WAC

284-17-120	Examination procedures for agents, solicitors and adjusters.
284-17-125	Prohibited acts or practices by license examinees.
284-17-130	Prerequisites to admittance to examination.
284-17-135	Reexamination after failure to pass.
284-17-175	Education referrals.
284-17-235	Exception to the advanced approval requirement.
284-17-275	Courses not approved.
284-17-505	Definitions.
284-17-510	Prelicensure education requirement.
284-17-515	Waiver of the prelicensure education requirement.
284-17-520	When prelicensure education requirement must be met.
284-17-530	Requirements applicable to all prelicensure education providers.
284-17-535	Program director qualifications and responsibilities.
284-17-537	Instructor qualifications and responsibilities.
284-17-539	Certificates of completion.

284-17-540	Requirements applicable to independent prelicensure education providers.
284-17-545	Requirements applicable to insurer prelicensure education providers.
284-17-550	Course standards.
284-17-551	Statutes and regulations curriculum.
284-17-552	Life insurance curriculum.
284-17-553	Disability insurance curriculum.
284-17-554	Casualty insurance curriculum.
284-17-555	Property insurance curriculum.
284-17-560	Providers not approved.
284-17-565	Approved providers—Loss of approval.
284-17-570	Implementation dates.

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.

[Statutory Authority: RCW 48.02.060. 88-24-054 (Order R 88-13), § 284-17-120, filed 12/7/88; 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 284-17-125 Prohibited acts or practices by license examinees. The following are prohibited acts or practices:

(1) Conduct that compromises the security of insurance license examination materials, including but not limited to:

(a) Unauthorized appropriation of examination questions or materials; or

(b) Unauthorized reproduction or replication of any portion of an examination; or

(c) Aiding, by any means, the unauthorized reproduction or replication of an examination; or

(d) Providing examination questions or other examination information to any person or business engaged in preparing applicants to pass such examination; or

(e) Obtaining examination questions or materials for the purpose of furnishing the questions or materials to license applicants; or

(f) Unauthorized sale, distribution, purchase or possession of any portion of a previously administered, current, or prospective examination; or

(g) Taking or attempting to take an examination in the line of insurance for which the examinee is already qualified.

(2) Behavior that undermines the evaluative objective of the examination, including but not limited to:

(a) Communication with any other examinee during the examination period; or

(b) Copying answers or allowing another to copy answers;

(c) Possession of any books, materials, notes, or photography or recording devices not issued by the independent testing service representative;

(d) Impersonating, or engaging another to impersonate, any applicant for the purpose of completing the examination on behalf of another.

[Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-125, filed 11/16/88.]

WAC 284-17-130 Prerequisites to admittance to examination. As a prerequisite to admittance to any examination designed to test the examinee's qualifications to be an agent, broker, solicitor or adjuster, each applicant must certify on the form provided, that he or she:

(1) Is not taking the examination for purposes other than as the means to qualify for a license;

(2) Has not passed the examination for that line of insurance, within the previous two-year period;

(3) Has been advised that the performance of any of the acts proscribed by WAC 284-17-125 constitutes a violation of RCW 48.17.530 and 48.17.560, as well as other statutes and regulations, and subjects the offender to disciplinary action, including refusal to issue an insurance license to the offender, revocation of any insurance license held by the offender, and the imposition of a fine; and

(4) Has been advised that the unauthorized appropriation or conversion of questions or materials comprising the examination for a Washington state insurance agent's, broker's, adjuster's, or solicitor's license is a violation of federal copyright law.

[Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-130, filed 11/16/88.]

WAC 284-17-135 Reexamination after failure to pass. An applicant who fails on the third attempt to pass an insurance license examination will not be eligible for further examinations, covering the same line or lines of insurance, for a period of one year from the date of the last failed examination.

[Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-135, filed 11/16/88.]

WAC 284-17-175 Education referrals. It shall be unlawful for any person to accept any rebate, refund, fee, commission, or discount in connection with referrals of students to an insurance education prelicense or continuing education provider, without making full disclosure to each student so referred.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-175, filed 12/16/88.]

WAC 284-17-235 Exception to the advanced approval requirement. (1) An individual licensee may attend and seek credit for completion of courses organized by, and conducted under the supervision of:

(a) Industry trade associations; or

(b) National associations of agents or brokers; or

(c) Such other national organizations as are accepted by the commissioner. The licensee may, within sixty days of course completion, submit course outlines and a request for credit hour approval to the commissioner.

(2) The licensee seeking course approval for continuing education credit shall provide:

(a) Sufficient supporting materials regarding course content and credit hours sought, to permit the commissioner to make an informed determination of the educational value of the course; and

(b) A document signed by the instructor or person in charge verifying licensee's attendance at, and completion of, each portion of the seminar for which credit is sought.

[Statutory Authority: RCW 48.02.060. 88-01-074 (Order R 87-12), § 284-17-235, filed 12/18/87, effective 3/1/88.]

WAC 284-17-275 Courses not approved. A course will not be approved if any requirement of this chapter is not met, or if the instructor or the sponsoring organization:

(1) Lacks education or experience in the subject matter of the proposed course; or

(2) Has a history of noncompliance with insurance statutes or regulations; or

(3) Has had an insurance license revoked.

[Statutory Authority: RCW 48.02.060. 88-01-074 (Order R 87-12), § 284-17-275, filed 12/18/87, effective 3/1/88.]

WAC 284-17-505 Definitions. As used in WAC 284-17-505 through 284-17-565, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Approved prelicense education provider" or "provider" means any insurer, professional association,

community college, or independent contractor to which the commissioner has granted authority to conduct and certify completion of an approved course.

(2) "Approved course" means a series of seminars, classes, or lectures meeting the requirements of WAC 284-17-550; covering the prescribed curricula of WAC 284-17-551 and any of WAC 284-17-552 through 284-17-555. A course is approved only for offering by an approved provider, while supervised by an approved program director, and taught by an approved instructor, according to the applicable section of either WAC 284-17-540 or 284-17-545.

(3) "Student" means an individual taking the prelicense education course that is required as a prerequisite to admission to the life, disability, property, or casualty resident insurance agent's license examination.

(4) "Curriculum" or "curricula" means the topics of study prescribed for prelicense education by the commissioner at WAC 284-17-551 through 284-17-555, concerning the life, disability, property, and casualty lines of insurance, and including the Washington insurance statutes and regulations curriculum.

(5) "Independent testing service" means the entity with which the commissioner has contracted to develop, administer, and score license examinations.

(6) "Insurer" means an insurance company, health care service contractor, or health maintenance organization authorized to conduct business in Washington under RCW 48.05.030, 48.44.015, or 48.46.027, respectively.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-505, filed 12/16/88.]

WAC 284-17-510 Prelicense education requirement.

(1) Unless exempted under WAC 284-17-515, an applicant for a resident's license as a life, disability, property, or casualty insurance agent or solicitor must complete the following education requirements as a prerequisite to admission to the examination:

Complete four hours of instruction relating to Washington's general statutes and regulations governing the sale of insurance, and sixteen hours of instruction relating to the specific line of:

(a) Life insurance, if the applicant is seeking to be licensed as a life insurance agent or solicitor; or

(b) Disability insurance, if the applicant is seeking to be licensed as a disability insurance agent or solicitor; or

(c) Casualty insurance, if the applicant is seeking to be licensed as a casualty insurance agent or solicitor; or

(d) Property insurance, if the applicant is seeking to be licensed as a property insurance agent or solicitor.

(2) An applicant planning to undergo examination for more than one major line need not repeat the four hours' instruction on general statutes and regulations.

(3) The prescribed curriculum for a particular line, and the prescribed curriculum for the insurance statutes and regulations, must be completed within the twelve-month period immediately preceding the examination.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-510, filed 12/16/88.]

WAC 284-17-515 Waiver of the prelicense education requirement. Any person with documented insurance education that meets or exceeds the required prelicense education may file a written petition with the commissioner for a waiver of the requirement.

Any person who believes that a prelicense education course is unavailable to her or him may file a written petition with the commissioner for permission to undertake self-study.

(1) A written waiver, based on documentation of equivalent education, may be granted by the commissioner in lieu of the certificate of completion for the purpose of complying with the prelicense education requirement, provided that the insurance education was completed within the twelve months immediately preceding the petition for waiver; and the petitioner demonstrates that the materials and/or classes required to complete such insurance education meet or exceed the curriculum prescribed by WAC 284-17-552 through 284-17-555 for each applicable line.

(a) An equivalent education in insurance may be demonstrated by a course syllabus and the student's transcript from an accredited college, university, or a course of study recognized as a mark of distinction by the insurance industry and deemed by the commissioner to be fully qualified and competent.

(b) The commissioner retains the discretion to determine whether a petitioner has presented sufficient evidence that her or his "equivalent" education merits a waiver of the prelicense education requirement.

(c) Prior to the petitioner's participation in the insurance agent's license examination, the petition must be submitted and the commissioner's written waiver must be issued.

(d) A waiver is valid for twelve months from the date signed by the commissioner. A waiver of the applicable insurance line curriculum requirement is not a waiver of the insurance statutes and regulations curriculum requirement, or of any other requirement prescribed by the commissioner for insurance license examination eligibility.

(2) Written permission to undertake self-study of the prelicense education curricula, based on a showing of the unavailability of an approved prelicense education course, may be granted by the commissioner provided that the petition shall specify in detail the reasons why a prelicense education course for the identified line of insurance is unavailable, and shall identify with particularity the materials to be used to study the prescribed curricula. The petitioner shall demonstrate that the materials cover the curriculum prescribed for Washington insurance statutes and regulations as well as the curriculum prescribed for that line.

(a) The commissioner retains the discretion to determine whether the petitioner has presented sufficient cause to justify a grant of permission to self-study the prelicense curriculum.

(b) If the commissioner grants permission to self-study, such study must be completed within twelve months of the grant. Upon completion of study, the petitioner shall present to the commissioner a certified

statement in which the self-study materials that have been utilized are identified, and in which the amount of time spent in study is clearly recorded by dates and clock times as covering at least the prelicense education hour requirement.

(c) Upon the petitioner's satisfactory completion of the approved program of self-study, the commissioner will issue a certificate of completion of approved self-study.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-515, filed 12/16/88.]

WAC 284-17-520 When prelicense education requirement must be met. The requirements of WAC 284-17-505 through 284-17-520 apply to all persons taking an agent's license examination, conducted on or after July 1, 1989.

(1) Any applicant seeking a resident's license as a life, disability, property, or casualty insurance agent or solicitor in the state of Washington who appears at an examination site must present certificates of completion of the requisite number of hours of approved prelicense education, or a written waiver of the applicable line curriculum and a certificate of completion of the statutes and regulations curriculum, to be allowed access to the examination.

(2) Any applicant who receives a passing score on the licensing examination must include validated certificates of completion of the approved prelicense education, or a written waiver of the applicable line curriculum requirement, along with other license application documents, to be issued the license.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-520, filed 12/16/88.]

WAC 284-17-530 Requirements applicable to all prelicense education providers. This section applies to all persons offering life, disability, property, or casualty insurance prelicense education, for purposes of satisfying the education requirements prescribed by the commissioner at WAC 284-17-505 through 284-17-520 for insurance license applicants.

(1) Persons seeking authority to conduct an approved course for life, disability, property, or casualty insurance shall obtain the written approval from the commissioner prior to the commencement of any such course. No course may be advertised as approved until the provider has obtained in writing all approvals required from the commissioner.

(a) The request for approval must include all information, disclosures, statements, and certifications required by the commissioner, on the prescribed forms.

(b) Course materials must be submitted to the commissioner with references to the provisions of the prescribed curricula: *Provided, however,* That the commissioner may waive submission of materials that were approved within the previous twelve months, if references to the prescribed curriculum are drawn in sufficient detail. The provider shall submit a request for

approval only for those courses that satisfy the requirements of WAC 284-17-550, 284-17-551, and the applicable sections of WAC 284-17-552 through 284-17-555.

(c) The provider must disclose the tuition to be charged for each proposed course.

(i) Disclosure to the office of insurance commissioner of the total tuition to be charged for all course offerings shall be made in the request for provider approval.

(ii) The provider must disclose to each student at the time of enrollment the amount of the course tuition to be paid, to persons other than the provider's full-time employees, as compensation for referring students to the provider.

(iii) The provider must comply with the enrollment procedures set out at WAC 490-800-060 by the Washington state board for vocational education.

(2) The commissioner will look to the provider to maintain the integrity of the training system. The provider shall be responsible for its employees' conduct, and shall be subject to disciplinary action for its employees' failure to comply with chapter 284-17 WAC. As a condition of approval, therefore:

(a) The provider must retain all student enrollment and performance data, personnel records, and course materials and student evaluations of each course, available for the commissioner's review, for three years.

(b) The provider must identify its proposed program director, and must certify, upon conclusion of a competent background investigation, that its program director's qualifications meet or exceed the requirements at WAC 284-17-535, including that the program director has been determined to be trustworthy.

(i) The commissioner's approval of a program director is valid for a period of twelve months from the most recent provider approval date.

(ii) The provider must apply to the commissioner for amended approval at least ten calendar days before instituting a change of program director.

(iii) The provider must continually monitor its program director's supervision of instruction, and must immediately remove the program director if he or she violates any statute or regulation pertaining to insurance sales or licensing then in effect.

(c) The provider must identify its proposed instructor(s), and must certify, upon conclusion of a competent background investigation, that each instructor's qualifications meet or exceed the requirements at WAC 284-17-537, including that each instructor has been determined to be trustworthy.

(i) The commissioner's approval of each instructor is valid for a period of twelve months from the most recent provider approval date.

(ii) The provider must apply to the commissioner for amended approval at least ten calendar days before instituting a change of instructors, except in the case of an instructor vacancy created by an emergency as defined by WAC 284-17-535 (3)(a)(i).

(3) After due investigation and consideration, the commissioner may grant approval of the provider upon a

showing that the provider has satisfied all the requirements of WAC 284-17-530 through 284-17-539, 284-17-540 or 284-17-545, and 284-17-550.

(4) Provider approval is valid for a period of twelve months from the initial approval date. To retain such approval, approved prelicense education providers must:

(a) Post in a conspicuous location at the prelicense education site, the procedures for applying for an insurance agent's or solicitor's license, including all preexamination qualifications and a notice of prohibited examination behavior in the standard form prescribed by the commissioner.

(b) Apply to the commissioner for amended provider approval at least ten calendar days prior to instituting any change of its owner or executive officer or of its program director. Amended approval, if granted, is valid only until the original provider approval expiration date.

(c) Report to the commissioner, by the fifteenth day of each month, the name of each student receiving a certificate of completion for each approved course offered during the previous calendar month.

(d) Permit the commissioner or the commissioner's designees to conduct unannounced audits of any of the provider's approved courses, for purposes of monitoring the provider's continued compliance with WAC 284-17-530 through 284-17-565.

(e) Immediately produce, upon request of the commissioner or the commissioner's designee, a true and complete copy of the provider's instructional plan for each approved course.

(f) Post in a conspicuous location at the prelicense education site, the tuition for each approved course, and if applicable:

(i) The full text of any referral/rebate policy;

(ii) The specific dollar amount of course tuition which is payable, to each person other than the provider's full-time employees, as compensation for referring students to the provider;

(iii) The name(s) of the person(s) to whom referral fees are paid.

(g) Any approved provider that has a referral fee/tuition rebate plan must provide a written copy of the agreement to each referred student at the time of her or his enrollment. The copy must contain:

(i) The full text of any referral/rebate policy;

(ii) The specific dollar amount of course tuition which is payable, to each person other than the provider's full-time employee, as compensation for referring students to the provider;

(iii) The name(s) of the person(s) to whom referral fees are paid.

(5) The provider must notify the commissioner, in writing, of the provider's intent to terminate its prelicense education program at least ten calendar days prior to the termination.

(a) If the commissioner sends a written inquiry by certified mail, the provider must respond within ten calendar days.

(b) Failure to notify the commissioner of a course termination, or to respond to a written inquiry, within

the specified time limits will result in immediate loss of provider approval, and shall be so noted upon the record.

(6) The provider must give at least ten calendar days' notice to the commissioner of the provider's intent to change the tuition amount or the rebating policy, or to initiate a rebating policy with a person other than the provider's full-time employee.

(7) It shall be unlawful for any prelicense education provider to use license examination performance data for advertising or promotional purposes.

(8) It shall be unlawful for any prelicense education provider to use any name that implies or suggests that the provider is affiliated with either the office of insurance commissioner or with the independent testing service that conducts the examination, or to use any name that implies or suggests that the provider is the only person authorized to provide prelicense education in the state of Washington.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-530, filed 12/16/88.]

WAC 284-17-535 Program director qualifications and responsibilities. (1) A program director's necessary qualifications are:

(a) At least five years of teaching experience and knowledge of insurance products, principles, and laws.

(i) Each independent provider's program director must possess and hold in good standing a Washington agent's or broker's license.

(ii) Each insurer provider's program director must possess such a license or comparable scholastic or professional credentials that the commissioner deems equivalent to such a license.

(iii) The requirements of (a)(i) of this subsection shall not apply to program directors employed by approved providers governed by chapters 28B.19 and 28B.50 RCW, community colleges within Washington state.

(b) An employment history involving administrative educational experience.

(c) Trustworthiness. A program director is untrustworthy if he or she has violated any statute or regulation pertaining to insurance, or to any other regulated occupation; or has had an occupational license revoked in any state; or has been convicted of a crime evidencing lack of fitness to assume fiduciary duties.

(2) Information on the program director which must be submitted to the commissioner includes the full disclosure of any regulatory or legal action involving the program director's professional or occupational activities.

(3) A program director's responsibilities include:

(a) Conducting a competent background investigation to ascertain that each instructor is trustworthy and qualified under WAC 284-17-537 and under WAC 284-17-540 or 284-17-545 for the line of insurance he or she has been designated to instruct; except that:

(i) In the event of an emergency created by the unavoidable absence of an approved instructor, the program director may appoint an interim instructor who was not previously certified and approved, to complete the current course offering, however:

(ii) The program director must immediately notify the commissioner of the nature of the emergency, the name of the temporary instructor, and the date upon which the current course offering will conclude.

(iii) At the conclusion of the current course offering the program director and provider shall suspend operation of the affected course until an approved instructor is available to conduct the classes.

(b) Supervising each approved course and reviewing all completed student evaluations of the course; and

(c) Insuring that instructors properly issue certificates of completion according to WAC 284-17-539 to the students at the completion of each course.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-535, filed 12/16/88.]

WAC 284-17-537 Instructor qualifications and responsibilities. The provider must submit the name(s) of each proposed instructor to the commissioner.

(1) To qualify as an instructor for an approved provider, each proposed instructor must:

(a) Demonstrate any combination of at least three years of instructional experience and experience as a licensed insurance agent or broker.

(b) Be trustworthy. An instructor is untrustworthy if he or she has violated any statute or regulation pertaining to insurance, or to any other regulated occupation; or has had an occupational license revoked in any state; or has been convicted of a crime evidencing lack of fitness to assume fiduciary duties.

(c) Demonstrate competence in the line of insurance he or she proposes to teach:

(i) Each independent provider's instructor must possess and hold in good standing a Washington agent's or broker's license for the applicable line(s) of insurance.

(ii) Each insurer provider's instructor must possess such a license or scholastic or professional credentials that the commissioner deems equivalent to such a license.

(2) The instructor of each approved course shall perform the following instructional and administrative duties:

(a) At the beginning session of each approved course, assure that each student has been properly registered.

(b) Remain in the classroom for the duration of each scheduled class session.

(c) Teach the study materials, which incorporate the prescribed curriculum, according to the lesson plans filed with the commissioner.

(d) At the conclusion of the course, distribute the standard course evaluation form prescribed by the commissioner, to each student who has completed the course; and collect the completed forms.

(e) To each student who has completed the course, issue a certificate of completion by signing each certificate, and thereby certify that the student actually completed the course.

(f) Review course evaluations with the program director.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-537, filed 12/16/88.]

WAC 284-17-539 Certificates of completion. (1) A "certificate of completion," in the standard form prescribed by the commissioner, shall be completed in its entirety, signed by the instructor, and issued by the approved prelicense education provider to each student in the student's legal name, who has completed an approved course.

(2) Both the student and the instructor(s) shall certify that the course was conducted and completed according to the hours and curriculum required, by affixing their original signatures in the spaces provided on the certificate of completion.

(3) The provider shall indicate, on the face of the certificate of completion, the correct codes assigned by the commissioner to each approved prelicense education provider and to each approved course.

(4) The approved prelicense education provider must issue each valid certificate of completion within twenty-four hours from the time the course was completed.

(5) No instructor may issue a certificate of completion to herself or himself.

(6) Completion of less than the full course curriculum, or of individual classes, does not qualify for a certificate of completion.

(7) A valid certificate of completion (or a valid waiver) for the line of insurance on which the student will be examined, and a certificate of completion for the statutes and regulations curriculum, must be presented to the independent testing service as a prerequisite to participating in any of the agent's license examination(s) for life, disability, property, or casualty insurance.

(8) The certificate is valid for twelve months from the course completion date shown on its face.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-539, filed 12/16/88.]

WAC 284-17-540 Requirements applicable to independent prelicense education providers. This section applies to all persons, other than insurers, offering life, disability, property, or casualty insurance courses to license applicants for purposes of satisfying the educational requirement prescribed by WAC 284-17-505 through 284-17-520.

(1) In addition to the general conditions for approval set out at WAC 284-17-530 through 284-17-539, and in addition to complying with the requirements of WAC 284-17-550, each noninsurer prelicense education provider shall:

(a) Describe any existing insurance education program:

(i) Class titles and curricula covered;

(ii) Number of students per course during previous year;

(iii) Name(s) and qualifications of instructor(s);

(iv) Name and qualifications of person responsible for the previous program.

(b) Describe the changes necessary to bring any existing program into compliance with WAC 284-17-530 through 284-17-539, 284-17-550 and 284-17-551, and each applicable section of WAC 284-17-552 through 284-17-555.

(c) Reveal the provider's department of revenue registration number.

(2) To qualify a provider for the commissioner's approval, the provider's proposed program director must hold in good standing a valid Washington agent's or broker's license and present evidence of teaching experience, the combination to total a minimum of five consecutive years' qualifications. After January 1, 1994, the license(s) must have been held in good standing for at least five years.

(3) To qualify a provider for the commissioner's approval, each of the provider's proposed instructors must hold in good standing a valid Washington agent's or broker's license, for the line(s) of insurance he or she will be instructing, and present evidence of teaching experience, the combination to total a minimum of three consecutive years' qualifications. After January 1, 1992, the license(s) must have been held in good standing for at least three years.

(4) An independent provider shall establish and maintain records and an appropriate accounting system for all tuition payments received by the provider.

(a) All tuition funds received must be deposited promptly into a bank account or depository separate from any other account or depository.

(b) The accounting system used must effectively isolate the separate account from any other operating or personal accounts, and must provide an audit trail so that details underlying the summary data may be identified.

(c) The provider shall make such records available for inspection by the commissioner during regular business hours upon demand during the three years immediately after the date of the transaction.

(5) Noninsurer course providers shall have an exact physical location or locations, and all classes shall be scheduled on a regular and predictable basis.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-540, filed 12/16/88.]

WAC 284-17-545 Requirements applicable to insurer prelicense education providers. This section applies to all admitted insurers regulated by the commissioner, and offering life, disability, property, or casualty insurance education courses to license applicants for purposes of satisfying the educational requirements prescribed by WAC 284-17-505 through 284-17-520.

(1) In addition to the general conditions for approval set out at WAC 284-17-530 through 284-17-539, and in addition to complying with the requirements of WAC 284-17-550, each insurer applying for prelicense education provider approval must exhibit an existing, bona fide insurance education function which is supervised from the corporate level. The insurer shall:

(a) Describe the existing program:

(i) Class titles and curricula covered;

(ii) Number of students per course during previous year;

(iii) Name(s) and qualifications of instructor(s);

(iv) Name and qualifications of person responsible for the program.

(b) Describe the insurer's plan for agent development.

(c) Submit the prelicense education plan to be applied throughout Washington state.

(2) For each program director not licensed as a Washington agent or broker, the provider shall in the request for approval identify the program director's equivalent qualifications, including educational degrees or professional designations earned, and certified evidence of past insurance education and licenses held in this or other states, and identify the program director's past teaching experience.

(3) For each instructor not licensed as a Washington agent or broker in the line of insurance which is the subject of instruction, the insurer's program director shall in the request for approval identify the instructor's equivalent qualifications, including educational degrees or professional designations earned, and certified evidence of past insurance education and licenses held in this or other states.

(4) The commissioner retains discretion to determine whether the proposed instructor(s) and the proposed program director's asserted qualifications meet the minimum scholastic and professional criteria required herein.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-545, filed 12/16/88.]

WAC 284-17-550 Course standards. (1) No course will be approved unless the Washington insurance statutes and regulations applicable to the specific line are incorporated into each specific line(s) curriculum offered by the provider.

(2) To qualify for approval, each course shall be conducted by an approved instructor, utilizing study materials that include all the prescribed curriculum, and shall be presented under the supervision of an approved prelicense education provider.

(a) Each instructor's qualifications shall be identified, according to the requirements of WAC 284-17-530 (2)(d) and 284-17-537, and 284-17-540 or 284-17-545, for approval by the commissioner.

(b) The course instructor shall be present in the classroom at all times during the hours an approved course is presented.

(3) Each course shall be broken into individual lesson components covering the prescribed curriculum.

(a) Instruction may include coverage of related subject matter; however, such peripheral instruction must be presented in the individual lesson components as supplementary to the prescribed curriculum hours.

(b) The provider may choose the prelicense education study materials, and shall certify that the study materials include all of the prescribed curriculum.

(4) "Hours" are approved by the commissioner for an approved course. Each "hour" shall represent at least fifty minutes of actual instruction on a topic within the prescribed prelicense education curriculum.

(5) No course may be represented as approved until the approved prelicense education provider has received the commissioner's written approval of the instructor and of the course.

(a) Approved prelicense education providers must apply to the commissioner for amended course approval if any of the following changes or revisions are instituted before the original course approval expiration date:

- (i) Change of study materials;
- (ii) Change of program schedule or location; or
- (iii) Change of course tuition or rebate policy.

(b) Amended approval, if granted, is valid only until the original course approval expiration date.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-550, filed 12/16/88.]

WAC 284-17-551 Statutes and regulations curriculum. Every prelicense education course shall incorporate study of the:

- (1) Nature of insurance:
 - (a) Definition of insurance; insurance transaction;
 - (b) Public interest;
 - (c) Risk management;
 - (d) Law of large numbers;
 - (e) Indemnification.
- (2) Insurance commissioner:
 - (a) Authority and duties;
 - (b) Rate and form filings;
 - (c) Examinations:
 - (i) Insurers' financial status;
 - (ii) License applicant's qualifications.
 - (d) Hearings and appeals;
 - (e) Public access to records.
- (3) Insurers:
 - (a) Definitions:
 - (i) Domestic, foreign, alien;
 - (ii) Life, disability – stock, mutual, fraternal;
 - (iii) Property, casualty, vehicle, surety – stock, mutual, reciprocal, Lloyds;
 - (iv) Authorized, unauthorized insurers; certificate of authority.
 - (b) Financial status:
 - (i) Mergers, insider trading;
 - (ii) Rehabilitation, liquidation; Washington Insurance Guaranty Associations.
 - (c) Insuring powers – defining the separate lines;
 - (d) Assets and liabilities:
 - (i) Investments;
 - (ii) Reserves.
 - (e) Fees and taxes.
 - (4) The insurance contract:
 - (a) General provisions;
 - (b) Exclusions and limitations;
 - (c) Insured;
 - (d) Cancellation and nonrenewal;
 - (e) Premium;
 - (f) Binder.
 - (5) Agents, brokers, solicitors, adjusters:
 - (a) Company appointment or affiliation:
 - (i) Purpose, contractual authority, and liability;
 - (ii) Termination.
 - (b) Types of licenses:
 - (i) Authority and liability under the regulation:
 - (A) Solicitor;
 - (B) Agent;

- (C) Broker;
- (D) Surplus lines broker;
- (E) Adjuster: Independent, public.
- (ii) Major lines:
 - (A) Life insurance;
 - (B) Disability insurance;
 - (C) Property insurance;
 - (D) Casualty insurance.
- (iii) Limited lines:
 - (A) Vehicle insurance;
 - (B) Surety;
 - (C) Credit life and disability;
 - (D) Travel insurance.
- (c) Licensing requirements:
 - (i) Purpose;
 - (ii) Licensing procedures:
 - (A) Resident;
 - (B) Nonresident.
 - (iii) Continuing education; renewal procedures;
 - (iv) Penalties for misconduct;
 - (v) Exemption from the licensing requirement;
 - (vi) Temporary license.
- (d) Agent responsibilities:
 - (i) Recordkeeping;
 - (ii) Reply promptly to inquiry by the commissioner; notify the commissioner of a change of address;
 - (iii) Application completion;
 - (iv) Delivery of the policy;
 - (v) Fiduciary accountability; separate account.
- (e) Unfair practices and frauds:
 - (i) Advertising, comparisons, and defamation;
 - (ii) Charges, inducements, rebating;
 - (iii) Misrepresentation, twisting;
 - (iv) Discrimination.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-551, filed 12/16/88.]

WAC 284-17-552 Life insurance curriculum. (1) Life insurance needs:

- (a) Monetary value of human life;
- (b) Social security:
 - (i) Contributions;
 - (ii) Qualification and restrictions;
 - (iii) Benefit periods;
 - (iv) Blackout period.
- (c) Federal government employee/military benefits/railroad retirement benefits;
- (d) Needs analysis:
 - (i) Premature death/retirement;
 - (ii) Theory of decreasing need;
 - (iii) Earnings approach, depletion approach;
 - (iv) Capital retention/estate conservation;
 - (v) Mortality/life expectancy tables.
- (2) Types and characteristics of life insurance policies:
 - (a) Term insurance policies:
 - (i) Level, decreasing or increasing benefit;
 - (ii) Renewable;
 - (iii) Convertible;
 - (iv) Reentry.
 - (b) Whole life policy concepts:
 - (i) Economic values of whole life;

- (ii) Basic types of whole life:
 - (A) Ordinary;
 - (B) Limited pay.
 - (c) Endowment;
 - (d) Universal life:
 - (i) Fixed premium;
 - (ii) Variable.
 - (e) Single premium whole life:
 - (i) Fixed;
 - (ii) Variable.
 - (f) Annuities:
 - (i) Nature and purpose;
 - (ii) Tax-qualified plans; nonqualified plans;
 - (iii) Premium payment methods:
 - (A) Single;
 - (B) Fixed installment/periodic;
 - (C) Flexible.
 - (iv) When benefits begin;
 - (v) Payout options:
 - (A) Period certain;
 - (B) Interest only;
 - (C) Fixed/variable;
 - (D) Number of lives covered.
 - (3) Other life insurance products:
 - (a) Keogh;
 - (b) Individual retirement account (IRA);
 - (c) Simplified employee pension plan (SEP);
 - (d) Key person;
 - (e) Buy-sell;
 - (f) Split dollar;
 - (g) Executive bonus.
 - (4) Group life insurance:
 - (a) Types of contracts:
 - (i) Term;
 - (ii) Contracts with permanent benefits;
 - (iii) Credit or mortgage life.
 - (b) Group underwriting principles;
 - (c) Master policy and certificates;
 - (d) Conversion rights and limitations.
 - (5) Combination policies/variations in basic forms:
 - (a) Double or triple protection;
 - (b) Term riders;
 - (c) Family policies/riders;
 - (d) Family income, family maintenance;
 - (e) Retirement income;
 - (f) Face amount plus cash value/return of premium;
 - (g) Mortgage protection.
 - (h) Credit life insurance;
 - (i) Joint life;
 - (j) Last survivor;
 - (k) Juvenile;
 - (l) Adjustable life;
 - (m) Variable life.
 - (6) Life insurance statutes and regulations:
 - (a) Disclosure;
 - (b) Fair Credit Reporting Act;
 - (c) Replacement;
 - (d) Washington Life and Disability Insurance Guaranty Association;
 - (e) Fraternal benefit society;
 - (f) Standard nonforfeiture law.
- (7) Regulated life insurance contract provisions:
 - (a) Free look;
 - (b) Representations;
 - (c) Incontestability;
 - (d) Misstatement of age or sex;
 - (e) Grace period/reinstatement;
 - (f) Settlement on proof of death;
 - (g) Uniform Simultaneous Death Act.
 - (8) General provisions and clauses:
 - (a) Consideration/premium payment:
 - (i) Single;
 - (ii) Level;
 - (iii) Adjustable;
 - (iv) Modified;
 - (v) Graded.
 - (b) Insuring agreement;
 - (c) Owner/applicant/insured;
 - (d) Assignment;
 - (e) Limitation of liability:
 - (i) Act of war;
 - (ii) Suicide within two years of issue;
 - (iii) Specific aviation conditions.
 - (f) Morbidity and mortality tables;
 - (g) Age, health, marital status, occupation;
 - (h) Policy riders:
 - (i) Policy loan provision;
 - (ii) Automatic premium loan;
 - (iii) Waiver of premium;
 - (iv) Guaranteed insurability;
 - (v) Dividends/excess interest declarations;
 - (vi) Nonforfeiture values, annuity tables;
 - (vii) Accidental death/dismemberment.
 - (i) Beneficiary designations:
 - (i) Beneficiary categories:
 - (A) Estate/named party/class;
 - (B) Primary/contingent;
 - (C) Revocable/irrevocable;
 - (D) Trust.
 - (ii) Common disaster, short-term survivorship; Uniform Simultaneous Death Act;
 - (iii) Minor as beneficiary;
 - (iv) Changing the beneficiary.
 - (9) Application process:
 - (a) Short form/long form application;
 - (b) Application as part of contract;
 - (c) When coverage begins:
 - (i) Receipt;
 - (ii) Binder.
 - (10) Policy delivery:
 - (a) Modified/issued as requested;
 - (b) Explanation of coverage;
 - (c) Payment of premium:
 - (i) Paid upon application;
 - (ii) Paid upon delivery;
 - (iii) Mode of payment;
 - (iv) Effect of nonpayment.
 - (d) Good health upon delivery;
 - (e) Ten-day free look.
 - (11) Claims process:
 - (a) Notice of claim;
 - (b) Proof of loss;

- (c) Statute of limitations on claims/defenses;
- (d) Settlement options:
 - (i) Right to elect or change:
 - (A) Owner's right;
 - (B) Beneficiary's right.
 - (ii) Lump sum;
 - (iii) Interest only;
 - (iv) Period certain, fixed amount.
- (12) Federal taxation:
 - (a) Life insurance premiums;
 - (b) Proceeds;
 - (c) Dividends;
 - (d) Policy loans/withdrawals.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-552, filed 12/16/88.]

WAC 284-17-553 Disability insurance curriculum.

- (1) Nature and purpose:
 - (a) Medical expenses;
 - (b) Loss of income;
 - (c) Defining disability:
 - (i) Temporary/permanent;
 - (ii) Partial/total – normal occupation/any occupation.
 - (d) Accidental death/dismemberment;
 - (e) Needs analysis: Human life value, economic value.
- (2) Underwriting considerations:
 - (a) Costs of illness or injury; morbidity tables:
 - (i) Age, sex, height, and weight;
 - (ii) Marital, financial status;
 - (iii) Occupation, avocation;
 - (iv) Current state of health.
 - (b) Rating standards:
 - (i) Reasonable, equitable, adequate;
 - (ii) Class exposures to a degree of risk.
- (3) Disability insurance policy provisions:
 - (a) Mandatory individual policy provisions:
 - (i) Grace period;
 - (ii) Reinstatement;
 - (iii) Misstatement of age or sex;
 - (iv) Change of beneficiary.
 - (b) Optional individual policy provisions and clauses:
 - (i) Unpaid premium;
 - (ii) Cancellation/renewability;
 - (iii) Nonoccupation/full coverage;
 - (iv) Change of occupation;
 - (v) Other insurance with this insurer;
 - (vi) Insurance with other insurer(s):
 - (A) On expense incurred basis;
 - (B) On another basis.
 - (c) Other provisions applicable to group or individual:
 - (i) Consideration/premium payment:
 - (A) Modes of payment;
 - (B) Effect of nonpayment.
 - (ii) Waiver of premium;
 - (iii) Policy continuation:
 - (A) Cancellable;
 - (B) Optionally renewable;
 - (C) Conditionally renewable;
 - (D) Guaranteed renewable;
 - (E) Noncancellable.
 - (iv) Preexisting conditions;

- (v) Ten-day free look;
- (vi) Claims control:
 - (A) Second surgical opinion;
 - (B) Precertification;
 - (C) Ambulatory treatment.
- (vii) Assignment of benefits.
- (4) Disability income policies:
 - (a) Types of coverage:
 - (i) Disability benefits in life insurance contract;
 - (ii) Group, individual;
 - (iii) Credit protection/mortgage protection;
 - (iv) Hospital income insurance;
 - (v) Business overhead expense.
 - (b) Standard policy provisions for income replacement:
 - (i) Waiting period;
 - (ii) Relation of earnings to insurance;
 - (iii) Nonduplication of benefits:
 - (A) Other insurers;
 - (B) Benefit maximum.
 - (c) Special policy provisions:
 - (i) Disability buy-out:
 - (A) Lump sum;
 - (B) Periodic payment;
 - (ii) Specified injury or illness.
 - (d) Benefit periods:
 - (i) Long term/short term;
 - (ii) Illness/injury.
 - (e) Benefit features, options:
 - (i) Cost of living adjustment;
 - (ii) Medical expense of accident;
 - (iii) Guaranteed insurability;
 - (iv) Accidental death or dismemberment;
 - (v) Social Security rider.
 - (5) Sources of medical (accident and health) benefits:
 - (a) Health care service contractors (HCSC);
 - (b) May include preferred providers (PPOs);
 - (c) Health maintenance organizations (HMOs);
 - (d) Health insurance (indemnification) companies;
 - (e) Health Insurance Coverage Access Act:
 - (i) Nature and purpose;
 - (ii) Eligibility;
 - (iii) Coverage available.
 - (6) Medical expense policies/medical service benefits:
 - (a) Insuring agreements and perils covered:
 - (i) Hospital expense;
 - (ii) Surgical expense;
 - (iii) Regular medical expense;
 - (iv) Major medical.
 - (b) Standard contract provisions:
 - (i) Mandated benefits and mandated options;
 - (ii) Expenses covered;
 - (iii) Exclusions/limitations;
 - (iv) Waiting period, preexisting/named conditions.
 - (c) Common limitations/exclusions/optional coverages:
 - (i) Self-inflicted injury;
 - (ii) Injured while engaged in illegal activity or under the influence of a controlled substance;
 - (iii) Injury caused by military conflict;
 - (iv) Elective cosmetic surgery;

- (v) Optical, dental, audio care;
- (vi) Maternity and childbirth;
- (vii) Prescription drugs.
- (d) Limitations on insurer's expenses:
 - (i) Benefit deductibles;
 - (ii) Coinsurance, copayment, stop loss;
 - (iii) Waiting period;
 - (iv) Benefit maximum;
 - (v) Standards for coordination of benefits/nonduplication of benefits;
 - (vi) Government entitlement programs.
- (7) Other individual disability coverages:
 - (a) Long-term care:
 - (i) Nature and purpose;
 - (ii) Policies and contracts;
 - (iii) Skilled/intermediate care;
 - (iv) Disclosure;
 - (v) Prohibited practices;
 - (vi) Free look.
 - (b) Medicare supplement:
 - (i) Nature and purpose;
 - (ii) Minimum standards;
 - (iii) Preexisting conditions;
 - (iv) Disclosure;
 - (v) Renewability;
 - (vi) Replacement.
 - (c) Specified disease insurance.
- (8) Group policy considerations:
 - (a) Group enrollment restrictions:
 - (i) Age of applicant;
 - (ii) Coverage for dependents;
 - (iii) Time period for enrollment;
 - (iv) Preexisting condition.
 - (b) Types of benefits;
 - (c) Group underwriting considerations;
 - (d) Master policy and certificates;
 - (e) Approaches:
 - (i) Franchise coverage;
 - (ii) Blanket coverage.
 - (f) Mandatory benefits and options;
 - (g) Conversion option;
 - (h) Consolidated Omnibus Budget Reconciliation Act (COBRA).
 - (9) Policy delivery:
 - (a) Modified versus issued as requested;
 - (b) Explanation of coverage;
 - (c) Payment of premium:
 - (i) Paid upon application;
 - (ii) Paid upon delivery;
 - (iii) Mode of payment;
 - (iv) Effect of nonpayment.
 - (d) Good health upon delivery;
 - (e) Ten-day free look.
 - (10) Insurance statutes and regulations:
 - (a) Applicable to disability insurers only:
 - (i) Disability insurance advertising restrictions;
 - (ii) Group/blanket disability insurance:
 - (A) Extended health;
 - (B) Disability insurance loss ratios.
 - (iii) Washington Life and Disability Insurance Guaranty Association;

- (iv) Trade practices:
 - (A) Trade practice rules;
 - (B) Unfair claims practices.
 - (b) Applicable to all medical services coverage carriers:
 - (i) Standards for group chemical dependency coverage;
 - (ii) Rules pertaining to AIDS;
 - (iii) Health Care False Claim Act.
 - (11) Claims:
 - (a) Notice, forms, time limit;
 - (b) Proof of claim: Physical examination/autopsy;
 - (c) Legal action:
 - (i) Statute of limitations;
 - (ii) Coordination of benefits.
 - (d) Settlement:
 - (i) Payment of claims;
 - (ii) Time and method of payment.
 - (12) Federal taxation:
 - (a) Premiums;
 - (b) Benefits.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-553, filed 12/16/88.]

WAC 284-17-554 Casualty insurance curriculum.

- (1) Defining casualty insurance. Insurable interest; insured's legal liability for:
 - (a) Bodily injury, disability or death of any human being:
 - (i) Medical, hospital, surgical costs;
 - (ii) Funeral benefits.
 - (b) Liability for loss of/damage to the property of others:
 - (c) Coverage for personal injury:
 - (i) Libel, slander, defamation of character;
 - (ii) Wrongful eviction.
 - (d) Any other kind of loss, damage, or liability which is:
 - (i) Properly the subject of insurance;
 - (ii) Not within another insurance definition; and
 - (iii) Not contrary to law or public policy.
 - (2) Legal basis for liability:
 - (a) Intentional tort;
 - (b) Statutory liability;
 - (c) Product/absolute/strict liability;
 - (d) Negligence:
 - (i) Principles:
 - (A) Duty of care;
 - (B) Breach of duty was proximate cause of injury;
 - (C) Injury in fact.
 - (ii) Defenses:
 - (A) Contributory negligence;
 - (B) Comparative negligence;
 - (C) Last clear chance;
 - (D) Assumption of risk.
 - (iii) Degrees of care owed to:
 - (A) Trespasser;
 - (B) Licensee;
 - (C) Invitee;
 - (D) Children.
- (iv) Reasonable person standard applied to:

- (A) Attractive nuisance;
- (B) Extra hazardous operations.
- (e) Sources of liability:
 - (i) Direct;
 - (ii) Contingent;
 - (iii) Contractual;
 - (iv) Vicarious.
- (3) Evaluating casualty insurance needs:
 - (a) Maximum probable loss:
 - (i) Personal injury;
 - (ii) Bodily injury;
 - (iii) Injury to insured's reputation;
 - (iv) Mental distress; insured's lost wages;
 - (v) Defense costs;
 - (vi) Property damage.
 - (b) Factors affecting rates:
 - (i) Risks, perils, hazards;
 - (ii) Personal, business habits;
 - (iii) Blanket/specific coverage;
 - (iv) Monoline/package policy;
 - (v) Other primary or excess insurance;
 - (vi) Experience rating;
 - (vii) Deposit premium/audit.
 - (c) Liability limits:
 - (i) Per person;
 - (ii) Per occurrence;
 - (iii) Aggregate;
 - (iv) Split/single limit.
 - (d) Occurrence policy; claims made policy;
 - (e) Application content and binders.
- (4) Major classes of policy provisions:
 - (a) Declarations:
 - (i) First named insured, additional insureds;
 - (ii) Policy period, policy territory, perils;
 - (iii) Liability limits.
 - (b) Insuring agreement;
 - (c) Conditions:
 - (i) Liberalization;
 - (ii) Subrogation;
 - (iii) Assignment.
 - (d) Exclusions;
 - (e) Definitions.
- (5) Homeowners (section II) coverage – ISO HO-84 and Washington amendatory endorsement HO-300 (01/89):
 - (a) Nature and eligibility;
 - (b) Liability insuring agreement/exclusions;
 - (c) Medical payment insuring agreement/exclusions;
 - (d) Additional coverages and conditions;
 - (e) Common endorsements:
 - (i) Business pursuits;
 - (ii) Permitted incidental occupancy;
 - (iii) Watercraft;
 - (iv) Additional resident premises rented to others.
 - (f) Other personal packages:
 - (i) Mobile home owner;
 - (ii) Farmowner.
 - (g) Miscellaneous personal casualty coverages:
 - (i) Umbrella;
 - (ii) Excess auto liability;
 - (iii) Recreational vehicles;
 - (iv) Watercraft/yacht.
- (6) Automobile coverage:
 - (a) Financial responsibility:
 - (i) Proof defined;
 - (ii) Persons required to show proof;
 - (iii) Methods of satisfying financial responsibility;
 - (iv) Penalty for noncompliance.
 - (b) Coverages:
 - (i) Bodily injury;
 - (ii) Personal injury protection;
 - (iii) Medical payments;
 - (iv) Property damage;
 - (v) Collision;
 - (vi) Other than collision;
 - (vii) Towing expense, rental reimbursement;
 - (viii) Supplementary payments;
 - (ix) Uninsured motorist;
 - (x) Under-insured motorist.
 - (c) Personal auto:
 - (i) Common policies and endorsements:
 - (A) Personal auto policy;
 - (B) Broad form named operator;
 - (C) Extended nonowned liability;
 - (D) Debt and financing coverage.
 - (ii) Cancellation or nonrenewal:
 - (A) By insured/by insurer;
 - (B) Statutory requirements, notice; return of premium;
 - (C) Trade practice regulations.
 - (d) Business auto:
 - (i) Owned;
 - (ii) Nonowned;
 - (iii) Hired;
 - (iv) Garage liability;
 - (v) Garagekeeper's liability.
- (7) Commercial casualty:
 - (a) Basic hazards:
 - (i) General liability;
 - (ii) Contractual liability;
 - (iii) Independent contractors;
 - (iv) Pollution/environmental impairment;
 - (v) Premises and operations;
 - (vi) Products and completed operations;
 - (vii) Personal and advertising injury.
 - (b) Types of commercial package policies:
 - (i) Commercial package policy;
 - (ii) Businessowner's policy (section II):
 - (A) Nature and purpose;
 - (B) Standard/special form;
 - (C) Coverages, exclusions;
 - (D) Optional coverages.
 - (c) Miscellaneous commercial casualty coverages:
 - (i) Legal liability;
 - (ii) Professional liability;
 - (iii) Director's/officer's liability;
 - (iv) Stop-gap;
 - (v) Umbrella;
 - (vi) Excess insurance;
 - (vii) Boiler and machinery;
 - (viii) Motor vehicle mechanical breakdown;
 - (ix) Ocean marine.

- (8) Crime coverage:
 - (a) Major perils:
 - (i) Forgery/alteration;
 - (ii) Theft/disappearance, destruction/vandalism;
 - (iii) Safe robbery;
 - (iv) Robbery, burglary.
 - (b) Primary crime coverage forms:
 - (i) Premises burglary;
 - (ii) Robbery and safe burglary;
 - (iii) Theft, disappearance and destruction.
 - (c) Fidelity:
 - (i) Employee dishonesty coverage form:
 - (A) Individual;
 - (B) Scheduled;
 - (C) Blanket.
 - (ii) Financial institution bond.
 - (d) Surety bond:
 - (i) Surety distinguished from insurance;
 - (ii) Parties to the contract;
 - (iii) Promise of the surety;
 - (iv) Major classes of surety bond.
 - (9) Government programs:
 - (a) Worker's compensation;
 - (b) The Jones Act;
 - (c) The Longshore and Harbor Workers' Act;
 - (d) National crime program;
 - (e) Washington automobile insurance plan.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-554, filed 12/16/88.]

WAC 284-17-555 Property insurance curriculum.

- (1) Defining property insurance:
 - (a) Loss of or damage to real or personal property;
 - (b) Loss of interest in real or personal property.
- (2) Evaluation of risk:
 - (a) Maximum probable loss:
 - (i) Direct loss;
 - (ii) Indirect loss.
 - (b) Factors affecting rates:
 - (i) Risks, perils, hazards;
 - (ii) Personal, business habits;
 - (iii) Blanket/specific coverage;
 - (iv) Coinsurance.
- (3) Personal insurance coverages:
 - (a) Dwelling property forms – basic, broad, or special:
 - (i) Nature and eligibility;
 - (ii) Property covered/excluded;
 - (iii) Perils covered/excluded;
 - (iv) Deductibles;
 - (v) Limitation on loss settlement;
 - (vi) Other conditions and provisions.
 - (b) Homeowners (section I) coverage – ISO HO-84 and Washington amendatory endorsement HO-300 (01/89):
 - (i) Nature and eligibility;
 - (ii) Property covered:
 - (A) Personal dwelling;
 - (B) Other appurtenant private structures;
 - (C) Unscheduled personal property;
 - (D) Additional living expense.

- (iii) Perils covered/excluded;
- (iv) Property limited/excluded;
- (v) Other provisions or conditions;
- (vi) Cancellation or nonrenewal:
 - (A) Statutory requirements, notice; return of premium;
 - (B) Trade practice regulations.
- (vii) Common endorsements:
 - (A) Replacement cost on contents;
 - (B) Guaranteed replacement cost on dwelling;
 - (C) Scheduled personal property;
 - (D) Earthquake;
 - (E) Inflation guard.
- (c) Other personal packages:
 - (i) Mobile home;
 - (ii) Farmowners.
- (4) Commercial property coverages:
 - (a) Property covered:
 - (i) Building;
 - (ii) Insured's business personal property;
 - (iii) Personal property of others.
 - (b) Cause of loss forms:
 - (i) Basic;
 - (ii) Broad;
 - (iii) Special.
 - (c) Property limited or excluded;
 - (d) Optional coverages;
 - (e) Conditions, provisions, and extensions of coverage;
 - (f) Types of commercial package policies:
 - (i) Commercial package policy;
 - (ii) Businessowner's policy (section I):
 - (A) Nature and purpose;
 - (B) Standard/special form;
 - (C) Coverages, exclusions;
 - (D) Property limited or excluded.
 - (g) Miscellaneous commercial property insurance:
 - (i) Business income:
 - (A) General nature;
 - (B) Losses covered.
 - (ii) Extra expense;
 - (iii) Glass;
 - (iv) Earthquake;
 - (v) Inland marine;
 - (vi) Ocean marine/yacht.
- (5) Government programs:
 - (a) National flood insurance program;
 - (b) Fair access to insurance requirements (FAIR) plan;
 - (c) Washington Insurance Guaranty Association;
 - (d) Federal crop insurance program.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-555, filed 12/16/88.]

WAC 284-17-560 Providers not approved. The commissioner may deny approval to any prelicense education provider based upon:

- (1) Such provider's refusal or failure to comply with any of the requirements of chapter 284-17 WAC, including but not limited to the provider's employment and use of an unqualified program director or instructor; or

(2) Any owner, operator, program director, instructor, or other employee of such provider has, directly or indirectly, compromised or attempted to compromise the integrity or security of Washington state licensing examination questions, or has induced another to do so; or

(3) Any owner, operator, program director, instructor, or other employee of such provider has been cited for noncompliance with any of the requirements of this chapter or chapter 284-12 WAC, or of any other statute or regulation pertaining to the sale of insurance or to insurance education; or has been cited for violations of statutes, regulations, or copyrights related to an examination for any occupational license.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-560, filed 12/16/88.]

WAC 284-17-565 Approved providers--Loss of approval. (1) The commissioner may suspend or revoke approval of any prelicense education provider based upon a finding that:

(a) Any owner, operator, program director, instructor, or other employee of such provider has failed to comply with any of the requirements of chapter 284-17 WAC, including but not limited to the failure to employ a qualified program director or instructor(s); or

(b) Any owner, operator, program director, instructor, or other employee of such provider has, directly or indirectly, compromised or attempted to compromise the integrity or security of Washington state licensing examination questions, or has induced another to do so; or

(c) Such provider has failed to maintain an effective instructional program, or has misrepresented the quality of the instruction provided, to the detriment of its students.

(2) The commissioner may suspend or revoke approval of any prelicense education provider based upon such provider's failure to:

(a) Reply promptly, in writing, to an inquiry of the commissioner.

(b) Submit revised course outlines requested by the commissioner. If changes are implemented in the prescribed prelicense curricula, affected providers must submit revised course outlines at least fifteen calendar days before the implementation date.

(c) Make timely disclosure to the office of insurance commissioner and to enrolling students at the time of their enrollment of any offer or payment of any rebate, refund, fee, commission, or discount to persons, other than the provider's full-time employees, in connection with referrals of students to the provider.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-565, filed 12/16/88.]

WAC 284-17-570 Implementation dates. WAC 284-17-530 through 284-17-565 concerning prelicense education providers shall be effective thirty calendar days from the date filed with the code reviser.

(1) Each person seeking initial provider approval, and intending to offer approved courses before July 1989,

must submit a request for provider approval to the commissioner before March 1, 1989.

(2) A request for provider approval that is received after March 1, 1989, may not be granted before July 1, 1989.

[Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-570, filed 12/16/88.]

Chapter 284-19 WAC

WASHINGTON ESSENTIAL PROPERTY INSURANCE INSPECTION AND PLACEMENT PROGRAM

WAC
284-19-200 Repealed.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-19-200 Termination of program. [Statutory Authority: RCW 48.02.060. 86-20-039 (Order R 86-4), § 284-19-200, filed 9/25/86; 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.] Repealed by 87-22-022 (Order R 87-11), filed 10/27/87. Statutory Authority: RCW 48.02.060.

WAC 284-19-200 Repealed. See Disposition Table at beginning of this chapter.

Chapter 284-23 WAC

WASHINGTON LIFE INSURANCE REGULATIONS

WAC
284-23-400 Purpose.
284-23-410 Definition of replacement.
284-23-420 Other definitions.
284-23-430 Exemptions.
284-23-440 Duties of agents and brokers.
284-23-450 Duties of all insurers.
284-23-455 Duties of insurers that use agents or brokers.
284-23-460 Duties of insurers with respect to direct-response sales.
284-23-470 Repealed.
284-23-480 Penalties.
284-23-485 Form to be used for notice regarding replacement.
284-23-490 Repealed.
284-23-500 Repealed.
284-23-510 Repealed.
284-23-520 Repealed.
284-23-530 Repealed.
284-23-550 Relationship of death benefits to premiums—Unfair practice defined.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-23-470 Duties of the existing insurer. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-470, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.
284-23-490 Effective date, supersedes prior regulation. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-490, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed

- 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.
- 284-23-500 Form to be used where the existing and proposed policies are written by different companies. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-500, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.
- 284-23-510 Form to be used where the existing and proposed policies are written by the same company. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-510, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.
- 284-23-520 Form to be used regarding replacement in a direct-response sale. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-520, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.
- 284-23-530 Form for comparative information. [Statutory Authority: RCW 48.02.060. 80-05-098 (Order R 80-5), § 284-23-530, filed 5/2/80, effective 10/1/80.] Repealed by 87-14-015 (Order R 87-6), filed 6/23/87, effective 9/1/87. Statutory Authority: RCW 48.02.060.

WAC 284-23-400 Purpose. The purpose of this regulation is:

- (1) To regulate the activities of insurers and agents and brokers with respect to the replacement of existing life insurance and annuities;
- (2) To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement transactions by:
 - (a) Assuring that the purchaser receives information with which a decision can be made in his or her own best interest;
 - (b) Reducing the opportunity for misrepresentation and incomplete disclosures; and
 - (c) Establishing penalties for failure to comply with the requirements of this regulation.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-400, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-400, filed 5/2/80, effective 10/1/80.]

WAC 284-23-410 Definition of replacement. "Replacement" means any transaction in which new life insurance or a new annuity is to be purchased, and it is known or should be known to the proposing agent or broker, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance or annuity has been or is to be:

- (1) Lapsed, forfeited, surrendered, or otherwise terminated;
- (2) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
- (3) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
- (4) Reissued with any reduction in cash value; or

(5) Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding twenty-five percent of the loan value set forth in the policy.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-410, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-410, filed 5/2/80, effective 10/1/80.]

WAC 284-23-420 Other definitions. (1) "Conservation" means any attempt by the existing insurer or its agent, or by a broker to dissuade a policyowner from the replacement of existing life insurance or annuity. Conservation does not include such routine administrative procedures as late payment reminders, late payment offers or reinstatement offers.

(2) "Direct-response sales" means any sale of life insurance or annuity where the insurer does not utilize an agent in the sale or delivery of the policy.

(3) "Existing insurer" means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of "replacement."

(4) "Existing life insurance or annuity" means any life insurance or annuity in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity that is within an unconditional refund period.

(5) "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract which is a replacement of existing life insurance or annuity.

(6) "Registered contract" means variable annuities, investment annuities, variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account, or any other contracts issued by life insurance companies which are registered with the Federal Securities and Exchange Commission.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-420, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-420, filed 5/2/80, effective 10/1/80.]

WAC 284-23-430 Exemptions. Unless otherwise specifically included, this regulation shall not apply to transactions involving:

- (1) Credit life insurance;
- (2) Group life insurance or group annuities, unless the new coverage under the insurance or annuity is solicited on an individual basis and the cost of such coverage is borne substantially by the individual;
- (3) An application to the existing insurer that issued the existing life insurance when a contractual change or conversion privilege is being exercised;
- (4) Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;
- (5) Transactions where the replacing insurer and the existing insurer are the same, or are subsidiaries or affiliates under common ownership or control; provided, however, agents or brokers proposing replacement shall

comply with the requirements of WAC 284-23-440 (1) and (2)(a) and (c); and

(6) Registered contracts shall be exempt only from the requirements of WAC 284-23-455 (2)(b) and (c), requiring provision of policy summary or ledger statement information; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required in lieu thereof.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-430, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-430, filed 5/2/80, effective 10/1/80.]

WAC 284-23-440 Duties of agents and brokers. (1)

Each agent or broker who initiates the application shall submit to the insurer to which an application for life insurance or annuity is presented, with or as part of each application:

(a) A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction; and

(b) A signed statement as to whether the agent or broker knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved, the agent or broker shall:

(a) Present to the applicant, not later than at the time of taking the application, a completed notice regarding replacement in the form as described in WAC 284-23-485, or other substantially similar form approved by the commissioner. Answers must be succinct and in simple nontechnical language. They should fairly and adequately highlight the points raised by the questions, without overwhelming the applicant with verbiage and data. An answer may include a reference to the contract or another source, but it must be essentially complete without the reference. The notice (and a copy) shall be signed by the applicant after it has been completed and signed by the agent or broker and the signed original shall be left with the applicant.

(b) Obtain with each application a list of all existing life insurance and/or annuity contracts to be replaced and properly identified by name of insurer, the insured and contract number. Such list shall be set forth on the notice regarding replacement required by WAC 284-23-485, immediately below the agent's or broker's name and address. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(c) Leave with the applicant the original or a copy of written or printed communications used for presentation to the applicant.

(d) Submit to the replacing insurer with the application, a copy of the replacement notice provided pursuant to WAC 284-23-440 (2)(a).

(3) Each agent or broker who uses written or printed communications in a conservation shall leave with the applicant the original or a copy of such materials used.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-440, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-440, filed 5/2/80, effective 10/1/80.]

WAC 284-23-450 Duties of all insurers. Each insurer shall:

(1) Inform its field representatives or other personnel responsible for compliance with this regulation of the requirements of this regulation.

(2) Require with or as part of each completed application for life insurance or annuity a statement signed by the applicant as to whether such proposed insurance or annuity will replace existing life insurance or annuity.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-450, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-450, filed 5/2/80, effective 10/1/80.]

WAC 284-23-455 Duties of insurers that use agents or brokers. Each insurer that uses an agent or broker in a life insurance or annuity sale shall:

(1) Require with or as part of each completed application for life insurance or annuity, a statement signed by the agent or broker as to whether he or she knows replacement is or may be involved in the transaction.

(2) Where a replacement is involved:

(a) Require from the agent or broker with the application for life insurance or annuity (i) a list of all of the applicant's existing life insurance or annuities to be replaced and (ii) a copy of the replacement notice provided the applicant pursuant to WAC 284-23-440 (2)(a). Such existing life insurance or annuity shall be identified by name of insurer, insured and contract number. If a number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(b) Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained pursuant to (a) of this subsection and a policy summary, contract summary, or ledger statement containing policy data on the proposed life insurance or annuity as required by the life insurance solicitation regulation, WAC 284-23-200 through 284-23-270, and/or the annuity and deposit fund disclosure regulation, WAC 284-23-300 through 284-23-380. Cost indices and equivalent level annual dividend figures need not be included in the policy summary or ledger statement. This written communication shall be made within three working days of the date the application is received in the replacing insurer's home or regional office, or the date the proposed policy or contract is issued, whichever is sooner.

(c) Each existing insurer or such insurer's agent or a broker that undertakes a conservation shall, within twenty days from the date the written communication plus the materials required in (a) and (b) of this subsection is received by the existing insurer, furnish the policyowner with a policy summary for the existing life insurance or a ledger statement containing policy data on the existing policy and/or annuity. Such policy summary or ledger statement shall be completed in accordance with the provisions of the life insurance solicitation regulation, WAC 284-23-200 through 284-23-270, except that information relating to premiums, cash values, death benefits and dividends, if any, shall be computed

from the current policy year of the existing life insurance. The policy summary or ledger statement shall include the amount of any outstanding indebtedness, the sum of any dividend accumulations or additions, and may include any other information that is not in violation of any regulation or statute. Cost indices and equivalent level annual dividend figures need not be included. When annuities are involved, the disclosure information shall be that required in a contract summary under the annuity and deposit fund disclosure regulation, WAC 284-23-300 through 284-23-380. The replacing insurer may request the existing insurer to furnish it with a copy of the summaries or ledger statement, which shall be furnished within five working days of the receipt of the request.

(3) The replacing insurer shall maintain evidence of the "Notice Regarding Replacement," the policy summary, the contract summary and any ledger statements used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced. The existing insurer shall maintain evidence of policy summaries, contract summaries or ledger statements used in any conservation. Evidence that all requirements were met shall be maintained for at least three years or until the conclusion of the next succeeding regular examination by the insurance department of its state of domicile, whichever is later.

(4) The replacing insurer shall provide in its policy or in a separate written notice which is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within twenty days commencing from the date of delivery of the policy.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-455, filed 6/23/87, effective 9/1/87.]

WAC 284-23-460 Duties of insurers with respect to direct-response sales. (1) If in the solicitation of a direct response sale, the insurer did not propose the replacement, and a replacement is involved, the insurer shall send to the applicant, with the policy, a replacement notice as described in WAC 284-23-485 or other substantially similar form approved by the commissioner. In such instances the insurer may omit the portion of the form which is included under the heading "Statement to Applicant by Agent or Broker," but including the portion beginning with "CAUTION" and continuing through the first three points down to and not including the fourth point which begins "Study the comments" without having to obtain approval of the form from the commissioner. The applicant's signature is not required on the notice.

(2) If the insurer proposes the replacement in connection with direct response sales, it shall:

(a) Provide to applicants or prospective applicants, with or as a part of the application, a replacement notice as described in WAC 284-23-485 or other substantially similar form approved by the commissioner.

(b) Request from the applicant with or as part of the application, a list of all existing life insurance or annuities to be replaced and properly identified by name of insurer, insured, and contract number.

(c) Comply with the requirements of WAC 284-23-455 (2)(b), if the applicant furnishes the names of the existing insurers, and the requirements of WAC 284-23-455(3), except that it need not maintain a replacement register.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-460, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-460, filed 5/2/80, effective 10/1/80.]

WAC 284-23-470 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-480 Penalties. (1) Any broker, and any insurer, agent, representative, officer or employee of such insurer failing to comply with the requirements of this regulation shall be subject to such penalties as may be appropriate under the insurance laws of Washington.

(2) This regulation does not prohibit the use of additional material other than that which is required that is not in violation of this regulation or any other Washington statute or regulation.

(3) Policyowners have the right to replace existing life insurance after indicating in or as part of the applications for life insurance that such is not their intention; however, patterns of such action by policyowners who purchase the replacing policies from the same agent or broker shall be deemed prima facie evidence of the licensee's knowledge that replacement was intended in connection with the sale of those policies, and such patterns of action shall be deemed prima facie evidence of the licensee's intent to violate this regulation.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-480, filed 6/23/87, effective 9/1/87; 80-05-098 (Order R 80-5), § 284-23-480, filed 5/2/80, effective 10/1/80.]

WAC 284-23-485 Form to be used for notice regarding replacement.

(Insurance company's name and address)

IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one—or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER:
(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? ...No ...Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy? ...No ...Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction? ...No ...Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law? ...No ...Yes, explain:
5.
 - a) Are interest earnings a consideration in this replacement? ...No ...Yes
 - b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid? ...No ...Yes, explain:
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
 - a) Are the interest rates quoted before...or after...fees and mortality charges have been deducted?
 - b) Interest rates are guaranteed for how long? -----
 - c) The minimum interest rate to be paid is how much? -----
 - d) If applicable, the rate you pay to borrow is -----, and the limit on the amount that can be borrowed is -----
 - e) The surrender charges are -----
 - f) The death benefit is -----
8. Are there other short or long term effects from the replacement that might be materially adverse? ...No ...Yes, explain:

CAUTION: The insurance commissioner suggests you consider these points:

> Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.

> Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

> You are entitled to advice from the existing agent or company. Such advice might be helpful.

> Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy

Received: -----
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

[Statutory Authority: RCW 48.02.060. 87-14-015 (Order R 87-6), § 284-23-485, filed 6/23/87, effective 9/1/87.]

WAC 284-23-490 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-500 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-510 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-520 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-530 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-23-550 Relationship of death benefits to premiums--Unfair practice defined. (1) It is an unfair practice for any insurer to provide life insurance coverage on any person through a policy or certificate of coverage delivered on or after April 1, 1989, to or on behalf of such person in this state, unless the benefit payable at death under such policy or certificate will equal or exceed the cumulative premiums, as defined in subsection (4) of this section, paid for the policy or certificate, plus interest thereon at the rate of six percent per annum compounded annually to the tenth anniversary of the effective date of coverage.

(2) This section applies to death benefits in relation to premiums, subject to the following provisions:

(a) When determining the relationship between benefits and premiums as set forth in subsection (1) of this section, neither premiums nor death benefits shall be adjusted for maturity benefits, surrender benefits, or policy loans.

Signature of Agent or Broker Date

Name of Agent or Broker (Print or Type) Address

List of Policies or Contracts to be Replaced:
Company Insured Contract No.

(b) Annuity benefits, including annuity death benefits, and the premiums therefor shall be disregarded in applying this section.

(c) The following benefits, but not the premiums therefor, shall be disregarded in applying this section:

- (i) Accidental death benefits;
- (ii) Permanent disability benefits; and
- (iii) Any benefit similar to (c)(i) or (ii) of this subsection.

(3) For coverage which varies by duration, including coverage provided through dividends, the "benefit payable at death" for purposes of this section is the sum of the least death benefit during each policy year, for the lesser of ten years or the term of the coverage, including renewals, divided by the number of death benefits included in said sum.

(4) "Cumulative premiums," for purposes of this section, means all sums paid as consideration, net of dividends paid in cash in an orderly progression, for the coverage during the first ten years of the coverage, excluding amounts which are designated in the policy or certificate as providing for annuity benefits.

(5) The benefits required by this section shall be provided contractually. If the policy or certificate must rely on dividends or "nonguaranteed" premiums or benefits to obtain compliance, then said policy or certificate shall contain a provision guaranteeing compliance.

(6) This section does not apply to:

- (a) Life insurance where the minimum death benefit is twenty-five thousand dollars or more; or
- (b) Group life insurance coverage unless the insured pays all or substantially all of the premium; or
- (c) Limited payment whole life insurance where the death benefit is constant and the premiums are level at all times, if the death benefit exceeds the total of all premium payments.

(7) Approval of the policy forms which do not comply with this section is hereby withdrawn effective April 1, 1989.

[Statutory Authority: RCW 48.02.060. 88-24-053 (Order R 88-12), § 284-23-550, filed 12/7/88.]

Chapter 284-30 WAC TRADE PRACTICES

WAC	
284-30-330	Specific unfair claims settlement practices defined.
284-30-350	Misrepresentation of policy provisions.
284-30-390	Standards for prompt, fair and equitable settlements applicable to automobile insurance.
284-30-500	Unfair practices with respect to vehicle insurance.
284-30-572	Discrimination prohibited.
284-30-574	Insurer must make independent evaluation.
284-30-590	Unfair practices with respect to policy cancellations, renewals, and changes.
284-30-620	Permissible time limit for benefits payable because of accidental injury or death.
284-30-630	Health questions in applications to be clear and precise.
284-30-650	Prompt responses required.
284-30-660	Deceptive use of quotations or evaluations prohibited.
284-30-750	Brokers' fees to be disclosed.
284-30-800	Unfair practices applicable to title insurers and their agents.

WAC 284-30-330 Specific unfair claims settlement practices defined. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Refusing to pay claims without conducting a reasonable investigation.

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to effectuate prompt payment of property damage claims to innocent third parties in clear liability situations. If two or more insurers are involved, they should arrange to make such payment, leaving to themselves the burden of apportioning it.

(7) Compelling insureds to institute or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

(10) Asserting to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failure to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days of notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of any such draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to an insured or claimant, it shall do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to an insured claimant to identify the claimant or to obtain details concerning the claim.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.]

WAC 284-30-350 Misrepresentation of policy provisions. (1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-350, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.]

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. Any settlement offer which relies upon prices of automobiles advertised for sale in local newspapers may include only prices for automobiles verified by the insurer as being comparable in age and condition to the insured automobile; or

(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. An insurer must accurately describe the age and condition of the insured automobile to the dealers surveyed and may use only price quotations for the retail selling price of a comparable automobile.

(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. An insurer shall keep first party claimants apprised of its efforts relative to subrogation claims.

(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, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-390, filed 4/21/87. 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, if the policy provides liability coverage for an insured's ownership, operation, or use of a motorcycle.

(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) Beginning July 1, 1987, it shall be an unfair practice for any insurer to consider traffic violations or accidents which occurred more than three years in the past, with respect to the acceptance, rejection, cancellation or nonrenewal of any insured under a private passenger automobile insurance policy, unless, because of the individual's violations, accidents or driving record during the three years immediately past, the earlier violations or

accidents are significantly relevant to the individual's qualifications for insurance.

(4) 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, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-500, filed 4/21/87. Statutory Authority: RCW 48.02.060 (3)(a), 85-02-019 (Order R 84-8), § 284-30-500, filed 12/27/84.]

WAC 284-30-572 Discrimination prohibited. (1) It shall be an unfair practice for any insurer to decline, cancel, or refuse to renew any homeowners, dwelling fire or vehicle insurance policy, or to vary its terms, rates, conditions or benefits, because of an insured's or applicant's race, creed, color, national origin, religion, or ability to read, write, or speak the English language.

(2) It is an unfair practice for any insurer, and a prohibited practice for any health care service contractor or health maintenance organization, to discourage a claimant or an insured from contacting the insurance commissioner, or to unfairly discriminate against such person because of such contact.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-572, filed 4/21/87.]

WAC 284-30-574 Insurer must make independent evaluation. It shall be an unfair practice for any insurer to rely solely on another insurer's denial, cancellation, or nonrenewal of insurance to support a denial or termination of coverage. In every case, an insurer must go behind another insurer's action and make its own independent decision on the merits. This section does not prohibit an insurer from denying a binder pending its evaluation of another insurer's action, and does not apply to an insurer-reinsurer relationship.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-574, filed 4/21/87.]

WAC 284-30-590 Unfair practices with respect to policy cancellations, renewals, and changes. (1) It is unfair practice to utilize a twenty-day notice to increase premiums by a change of rates or to change the terms of a policy to the adverse interest of the insured thereunder, except on a one time basis in connection with the renewal of a policy as permitted by RCW 48.18.2901(2), or to utilize such notice if it is not, by its contents, made clearly and specifically applicable to the particular policy and to the insured thereunder or does not provide sufficient information to enable the insured to understand the basic nature of any change in terms or to calculate any premium resulting from a change of rates.

(2) In the unusual situation where a contract permits a midterm change of rates or terms, other than in connection with a renewal, it is an unfair practice to effectuate such change with less than forty-five days advance written notice to the named insured, or to utilize a contract provision which is not set forth conspicuously in the

contract under an appropriate caption of sufficient prominence that it will not be minimized or rendered obscure.

(3) It is an unfair practice to effectuate a change of rates or terms other than prospectively. Such changes may be effective no sooner than the first day following the expiration of the required notice.

(4) If an insured elects to not continue coverage beyond the effective date of any change of rates or terms, it is an unfair practice to refund any premium on less than a pro rata basis.

(5) The cancellation and renewal provisions set forth in chapter 48.18 RCW do not apply to surplus line policies. To avoid unfair competition and to prevent unfair practices with respect to consumers, it is an unfair practice for any surplus line broker to procure any policy of insurance pursuant to chapter 48.15 RCW that is cancelable by less than ten days advance notice for nonpayment of premium and twenty days for any other reason, except as to a policy of insurance of a kind exempted by RCW 48.15.160. This rule shall not prevent the cancellation of a fire insurance policy on shorter notice in accord with chapter 48.53 RCW.

(6) Except where the insurance policy is providing excess liability or excess property insurance including so-called umbrella coverage, it is an unfair practice for an insurer to make a common practice of giving a notice of nonrenewal of an insurance policy followed by its offer to re-write the insurance, unless the proposed renewal insurance is substantially different from that under the expiring policy.

(7) Where the rate has not changed but an incorrect premium has been charged, if the insurer elects to make a midterm premium revision, it is an unfair practice to treat the insured less favorably than as follows:

(a) If the premium revision is necessary because of an error made by the insurer or its agent, the insurer shall:

(i) Notify the applicant or insured of the nature of the error and the amount of additional premium required; and

(ii) Offer to cancel the policy or binder pro rata based on the original (incorrect) premium for the period for which coverage was provided; or

(iii) Offer to continue the policy for its full term with the correct premium applying no earlier than twenty days after the notice of additional premium is mailed to the insured.

(b) If the premium revision results from erroneous or incomplete information supplied by the applicant or insured, the insurer shall:

(i) Correct the premium or rate retroactive to the effective date of the policy; and

(ii) Notify the applicant or insured of the reason for the amount of the change. If the insured is not willing to pay the additional premium billed, the insurer shall cancel the policy, with appropriate statutory notice for nonpayment of premium, and compute any return premium based on the correct premium.

(c) This subsection recognizes that an insurer may elect to allow an incorrect premium to remain in effect

to the end of the policy term because the insured is legally or equitably entitled to the benefit of a bargain made.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-590, filed 4/21/87.]

WAC 284-30-620 Permissible time limit for benefits payable because of accidental injury or death. Beginning January 1, 1988, it shall be an unfair practice for any insurer to deliver a policy of insurance in this state which provides for benefits in case of accidental death or accidental injury, if it limits the benefits payable thereunder to losses occurring within a stated period of time after the accident, unless such period of time extends for at least one year from the time of the accident. In other words, benefits for accidental death or for covered expenses incurred because of an accidental injury shall be paid if the covered death occurs, or the covered services are incurred, within one year of the accident.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-620, filed 4/21/87.]

WAC 284-30-630 Health questions in applications to be clear and precise. If an insurer, including a health care service contractor or a health maintenance organization, intends to rely on an applicant's or enrollee's answers to health questions in an application to determine eligibility for coverage or the existence of a preexisting condition, such questions must be clear and precise. Simply asking whether the applicant has been under the care of a physician during the preceding year, for example, is not sufficient to require a "yes" answer where the applicant has been using medications that were prescribed prior to the start of the preceding year and the applicant has not seen a physician for more than a year.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-630, filed 4/21/87.]

WAC 284-30-650 Prompt responses required. It is an unfair practice for an insurer, and a prohibited practice for a health care service contractor or a health maintenance organization, to fail to respond promptly to any inquiry from the insurance commissioner relative to the business of insurance. A lack of response within fifteen business days from receipt of an inquiry will be considered untimely. A response must be in writing, unless otherwise indicated in the inquiry.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-650, filed 4/21/87.]

WAC 284-30-660 Deceptive use of quotations or evaluations prohibited. (1) It is an unfair or deceptive practice and an unfair method of competition pursuant to RCW 48.30.010 for any insurance company, broker, agent, or solicitor in connection with the business of insurance, to utilize quotations or evaluations from rating or advisory services or other independent sources, in a manner likely to deceive the persons to whom the information is directed.

(2) Acts which are prohibited by this section include the following examples:

(a) If an insurer represents in its advertising that it has received an "A+" rating from an advisory service, such representation is deceptive unless it includes a clear explanation that such advisory service's practice is to rate insurance companies on the basis of "AAA," "AA," and declining to "A," if such is the case. The absence of such explanation would reasonably cause the ordinary person to believe falsely that the insurer had received the highest rating available from the service.

(b) Similarly, quoting figures or comments from a report, such as those representing claims paid or the capital or reserves or the quality of an insurer, in a manner to suggest that such figures or comments are impressive or that the report demonstrates the company to be particularly strong financially or of high quality relative to other companies, when such is not the case, creates a false impression and is deceptive.

[Statutory Authority: RCW 48.02.060. 88-24-053 (Order R 88-12), § 284-30-660, filed 12/7/88.]

WAC 284-30-750 Brokers' fees to be disclosed. It shall be an unfair practice for any broker providing services in connection with the procurement of insurance to charge a fee in excess of the usual commission which would be paid to an agent without having advised the insured or prospective insured, in writing, in advance of the rendering of services, that there will be a charge and its amount or the basis on which such charge will be determined.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-750, filed 4/21/87.]

WAC 284-30-800 Unfair practices applicable to title insurers and their agents. (1) RCW 48.30.140 and 48.30.150, pertaining to "rebating" and "illegal inducements," are applicable to title insurers and their agents. Because those statutes primarily affect inducements or gifts to an insured and an insured's employee or representative, they do not directly prevent similar conduct with respect to others who have considerable control or influence over the selection of the title insurer to be used in real estate transactions. As a result, insureds do not always have free choice or unbiased recommendations as to the title insurer selected. To prevent unfair methods of competition and unfair or deceptive acts or practices, this rule is adopted.

(2) It is an unfair method of competition and an unfair and deceptive act or practice for a title insurer or its agent, directly or indirectly, to offer, promise, allow, give, set off, or pay anything of value exceeding twelve dollars, calculated in the aggregate over a twelve-month period on a per person basis in the manner specified in RCW 48.30.140(4), to any person as an inducement, payment, or reward for placing or causing title insurance business to be given to the title insurer.

(3) Subsection (2) of this section specifically applies to and prohibits inducements, payments, and rewards to real estate agents and brokers, lawyers, mortgagees, mortgage loan brokers, financial institutions, escrow agents, persons who lend money for the purchase of real

estate or interests therein, building contractors, real estate developers and subdividers, and any other person who is or may be in a position to influence the selection of a title insurer, except advertising agencies, broadcasters, or publishers, and their agents and distributors, and bona fide employees and agents of title insurers, for routine advertising or other legitimate services.

(4) This section does not affect the relationship of a title insurer and its agent with insureds, prospective insureds, their employees or others acting on their behalf. That relationship continues to be subject to the limitations and restrictions set forth in the rebating and illegal inducement statutes, RCW 48.30.140 and 48.30.150, which continue to limit gifts, payments and other inducements to a five dollar maximum, per person, per year.

[Statutory Authority: RCW 48.02.060 (3)(a). 88-11-056 (Order R 88-6), § 284-30-800, filed 5/17/88.]

Chapter 284-32 WAC

PLAN OF OPERATION FOR WASHINGTON INSURANCE GUARANTY ASSOCIATION

WAC

284-32-140 Claim settlements of \$150,000 or more.

WAC 284-32-140 Claim settlements of \$150,000 or more. The board shall review, and approve by majority vote, claim settlements to be made by the association or its agents of one hundred and fifty thousand dollars or more.

[Statutory Authority: RCW 48.32.070. 88-05-001 (Order R 88-2), § 284-32-140, filed 2/4/88; Emergency and Permanent Order R-71-3, § 284-32-140, filed 12/9/71.]

Chapter 284-44 WAC

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

WAC

284-44-450 PKU formula coverage requirements and exceptions.

WAC 284-44-450 PKU formula coverage requirements and exceptions. (1) The purpose of this section is to effectuate the provisions of section 3, chapter 173, Laws of 1988, by establishing the requirements and exceptions with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU), applicable to health care service contractors registered pursuant to RCW 48.44.015.

(2) Each contract for health care services which is delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(b) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage;

(c) A contract that provides benefits for hospital services only or for custodial services only may limit the coverage for PKU formulas to a benefit that supplies the formula needed, or pays for the formula used, during time such services are provided.

(d) A contract which provides services or reimbursement exclusively for optometric or vision care services, dental or orthodontic services, podiatric services, ambulance services, mental health services, or chiropractic services need not provide coverage for PKU formula.

(e) A contract that is governed by 5 U.S.C. chapter 89 or 42 U.S.C. section 1395mm need not provide the PKU formula coverage.

(f) In response to the written request of a contractor, other contracts may exclude coverage for the PKU formula with the written consent of the commissioner upon a finding that such coverage would be inappropriate.

(3) Coverage for the formulas necessary for the treatment of phenylketonuria may be limited to the usual and customary charge for such formulas, and may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that deductibles, copayments, coinsurance or other reductions are applied to general expenses incurred for common sicknesses or disorders under the provisions of the particular contract. (Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than the amount that would be produced by application of the reimbursement formula for medically necessary treatment for common sicknesses or disorders.)

(4) The amount charged by a health care service contractor shall be no greater to a family or individual receiving benefits under the PKU formula coverage, by reason thereof, than to a family or individual under the same contract form or group contract who is not receiving such benefits.

(5) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no contractor shall cancel or decline to renew any contract, or restrict, modify, exclude, or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or covered person has phenylketonuria.

(6) For purposes of section 3, chapter 173, Laws of 1988, and this section, a contract is "renewed" when it is continued beyond the earliest date after September 1, 1988, upon which, at the contractor's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the contractor to take any such steps does not prevent the contract from being "renewed."

The intent of this subsection is to bring the PKU formula coverage under the maximum number of contracts possible at the earliest possible time, by permitting the contractor to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of a contract holder without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46-.200. 88-16-065 (Order R 88-7), § 284-44-450, filed 8/1/88.]

Chapter 284-46 WAC

HEALTH MAINTENANCE ORGANIZATIONS

WAC

284-46-100 PKU formula coverage requirements.

WAC 284-46-100 PKU formula coverage requirements. (1) The purpose of this section is to effectuate the provisions of section 4, chapter 173, Laws of 1988, by establishing the requirements with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU), applicable to health maintenance organizations.

(2) Any agreement for health care services delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(b) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage;

(c) A contract that is governed by 5 U.S.C. chapter 89 or 42 U.S.C. section 1395mm need not provide the PKU formula coverage; and

(d) In response to the written request of a health maintenance organization, other contracts may exclude coverage for the PKU formula with the written consent of the commissioner upon a finding that such coverage would be inappropriate.

(3) The amount charged by a health maintenance organization shall be no greater to a family or individual receiving benefits under the PKU formula coverage, by reason thereof, than to a family or individual under the same agreement form or group agreement who is not receiving such benefits.

(4) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no health maintenance organization shall cancel or decline to renew any contract, or restrict, modify, exclude, or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or covered person has phenylketonuria.

(5) For purposes of section 4, chapter 173, Laws of 1988, and this section, an agreement is "renewed" when it is continued beyond the earliest date after September 1, 1988, upon which, at the health maintenance organization's sole option:

(a) The agreement's termination could have been effectuated, for other than nonpayment of premium; or

(b) The agreement could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the organization to take any such steps does not prevent the agreement from being "renewed." The intent of this subsection is to bring the PKU formula coverage under the maximum number of agreements possible at the earliest possible time, by permitting the health maintenance organization to exclude such coverage from only those agreements as to which there exists a right of renewal on the part of an enrollee without any change in any provision of the agreement.

(6) Coverage for the formulas may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that such deductibles, copayments, coinsurance or other reductions do not exceed those applicable to common sicknesses or disorders in the particular contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46-.200. 88-16-065 (Order R 88-7), § 284-46-100, filed 8/1/88.]

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

284-50-260 PKU formula coverage requirements and exceptions.
284-50-305 Applicability and scope.

WAC 284-50-260 PKU formula coverage requirements and exceptions. (1) The purpose of this section is to effectuate the provisions of sections 1 and 2, chapter 173, Laws of 1988, by establishing the requirements and exceptions with respect to coverage for the formulas necessary for the treatment of phenylketonuria (PKU).

(2) Every group disability insurance contract, which is delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses shall provide coverage for the formulas necessary for the treatment of phenylketonuria, with the exception of the following contracts, which need not provide such coverage:

(a) A contract of "blanket disability insurance" as defined in RCW 48.21.040;

(b) A group contract designed to provide benefits on an "accident only" or "specified disease only" basis;

(c) A group contract subject to chapter 48.66 RCW and providing medicare supplemental insurance;

(d) A group contract subject to chapter 48.84 RCW and providing long-term care insurance; and

(e) A group contract as to which the commissioner, in writing, consents to the exclusion of PKU formula coverage, upon a finding that such coverage would be inappropriate to the contract.

(3) Every individual disability insurance contract, including a contract of "family expense disability insurance" as defined in RCW 48.20.340 and a contract on a "franchise plan" as defined in RCW 48.20.350, delivered or issued for delivery or renewed in this state on or after September 1, 1988, that insures for hospital or medical expenses, shall provide coverage for the formulas necessary for the treatment of phenylketonuria, subject to the following exceptions:

(a) A contract providing only hospital confinement indemnity coverage, as such coverage is defined in WAC 284-50-345, need not provide the PKU formula coverage;

(b) A contract limited to providing accident only coverage, as such coverage is defined in WAC 284-50-360, need not provide the PKU formula coverage;

(c) A contract providing only specified disease or specified accident coverage, as such coverage is defined in WAC 284-50-365, need not provide the PKU formula coverage;

(d) A contract providing limited benefit health insurance coverage, as such coverage is defined in WAC 284-50-370, need not provide the PKU coverage to the extent that the commissioner allows an exception;

(e) A contract providing basic hospital expense coverage, as such coverage is defined in WAC 284-50-335, may limit the coverage for PKU formulas to a benefit that is based on the cost of formula consumed during a covered hospital stay;

(f) A contract that is subject to chapter 48.66 RCW and provides medicare supplemental insurance need not provide the PKU formula coverage;

(g) A contract that is subject to chapter 48.84 RCW and provides long-term care insurance need not provide the PKU formula coverage; and

(h) A contract as to which the commissioner, in writing, consents to the exclusion of PKU formula coverage, upon a finding that such coverage would be inappropriate to the contract.

(4) Coverage for the formulas necessary for the treatment of phenylketonuria may be limited to the usual and customary charge for such formulas, and may be made subject to deductibles, copayments, coinsurance or other reductions only to the extent that deductibles, copayments, coinsurance or other reductions are applied to general expenses incurred for common sicknesses or disorders under the provisions of the particular contract. (Relating the PKU formula to a special expense benefit, such as a prescription drug benefit, is not acceptable unless it results in the PKU formula benefit being paid at an amount no less than the amount that would be produced by application of the reimbursement formula for medically necessary treatment for common sicknesses or disorders.)

(5) Premiums for an insured receiving benefits under the PKU formula coverage shall be no greater, by reason thereof, than the premiums for anyone else who is covered under the same form and who is not receiving such benefits.

(6) Preexisting condition provisions shall not be used with respect to PKU formula coverage, and no insurer

shall cancel or decline to renew any contract, or restrict, modify, exclude or reduce the amount of benefits payable or type of coverage provided in any contract, because an applicant or insured has phenylketonuria.

(7) For purposes of sections 1 and 2, chapter 173, Laws of 1988, and this section, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1988, upon which, at the insurer's sole option:

(a) The contract's termination could have been effectuated, for other than nonpayment of premium; or

(b) The contract could have been amended to add the PKU formula coverage, with, if justified, an appropriate rate increase for any increased cost in providing the PKU formula coverage under the contract.

The failure of the insurer to take any such steps does not prevent the contract from being "renewed." The intent of this subsection is to bring the PKU formula benefits under the maximum number of contracts possible at the earliest possible time, by permitting the insurer to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of the insured without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. 88-16-065 (Order R 88-7), § 284-50-260, filed 8/1/88.]

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. This regulation shall not apply to long-term care insurance policies or contracts, as such policies or contracts are defined in the Long-Term Care Insurance Act, chapter 48.84 RCW.

[Statutory Authority: RCW 48.02.060(3), 48.20.450 through 48.20.470 and chapter 48.84 RCW. 87-15-028 (Order R 87-8), § 284-50-305, filed 7/9/87, effective 1/1/88. 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.]

Chapter 284-53 WAC

STANDARDS FOR COVERAGE OF CHEMICAL DEPENDENCY

WAC

284-53-010 Standards for coverage of chemical dependency.

WAC 284-53-010 Standards for coverage of chemical dependency. Contractual provisions for chemical dependency required by RCW 48.21.180, 48.44.240, or 48.46.350 shall meet the following standards and administrative requirements.

(1) The coverage for chemical dependency shall provide payment toward reasonable charges for any medically necessary treatment and supporting services provided to covered individuals by an "approved treatment facility" approved pursuant to RCW 70.96A.020(2) or 69.54.030, which may include medical evaluations, psychiatric evaluations, room and board (inpatient only), psychotherapy (individual and group), counseling (individual and group), behavior therapy, recreation therapy, family therapy (individual and group) for the patient and covered persons, prescription drugs prescribed by an approved treatment facility, and supplies prescribed by an approved treatment facility. The coverage shall provide such payment whether the treatment or services are provided on an inpatient (resident) or an outpatient (nonresident) basis, except to the extent that inpatient or outpatient coverage is not provided to the individual insured for other common illnesses or disease. Inpatient coverage shall include detoxification if detoxification is not specifically included in other contract coverage.

(2) Except to the extent prohibited by this section, the coverage may be limited by provisions of the contract that are applicable to other benefits or services for other common illnesses or disease generally including, but not limited to, provisions relating to deductibles, coinsurance and copayments. However, coverage shall not be denied by reason of contract provisions which are not pertinent to the treatment of chemical dependency, such as provisions requiring a treatment facility to have surgical facilities or approval by the joint commission on accreditation of hospitals, that there be a physician in attendance, or that the exact date of onset be known.

(3) The minimum benefits for chemical dependency treatment, supporting services and detoxification shall be an amount which is the lesser of five thousand dollars, exclusive of deductibles, coinsurance and copayments, in any consecutive twenty-four-month period or an amount equal to the benefit limit in the contract applicable to the individual insured which would normally be applied to treatment of any common major illness or disease other than chemical dependency. The benefits may be limited to a lifetime maximum of not less than ten thousand dollars exclusive of deductibles, coinsurance and copayments, notwithstanding WAC 284-44-040(2). For purposes of determining the limitations allowed by this subsection, with regard to all benefits except the lifetime maximum a carrier may take credit for any benefits paid by any carrier on behalf of a covered individual for chemical dependency treatment and supporting services received in an immediately preceding twenty-four month period. For purposes of determining the lifetime maximum allowed by this subsection, calculation must be made on either a per contract or per carrier basis except that when one group contract holder has utilized one or more carriers or plans then a carrier may take credit for

amounts paid on behalf of a covered individual from January 1, 1987, onward under all past and current carriers and plans with respect to that group contract holder.

(4) Contract provisions subject to this rule:

(a) Shall not impose waiting periods or preexisting condition limitations on chemical dependency coverage, except that a carrier may impose a waiting period or preexisting condition limitation for chemical dependency treatment and supporting services to the extent that a waiting period or preexisting condition limitation is imposed for other common illnesses or disease.

(b) Shall not provide for the application of comparative statistical measures which are lacking in statistical reliability. Because of the limited number of approved treatment facilities in this state and the diversity of methodologies and fee structures, a measure based on the application of usual, customary and reasonable charges for overall chemical dependency treatment and supporting services is not currently acceptable but comparison of costs for specific components of such treatment and supporting services may be acceptable.

(c) Shall not deny reasonable benefits for actual treatment and services rendered solely because a course of treatment was interrupted or was not completed.

(d) May limit coverage to specific facilities but only if the carrier provides one or more reasonably available and conveniently located approved treatment facilities under RCW 70.96A.020(2) or 69.54.030 which alone or in combination offer both inpatient and outpatient care. This right to limit coverage to specific facilities will permit a carrier to limit diagnosis and treatment to that rendered by itself or by a facility to which it makes referrals, but, in either case, only if the facility is an approved treatment facility under RCW 70.96A.020(2) or 69.54.030.

(e) May require prenotification in all reasonable situations; may also require a second opinion if such second opinion is required under the contract generally for other common illnesses and disease. Prenotification with respect to detoxification in most cases would not be reasonable.

(5) In situations where an insured is under court order to undergo a chemical dependency assessment or treatment, or in situations related to deferral of prosecution, deferral of sentencing or suspended sentencing, or in situations pertaining to motor vehicle driving rights and the Washington state department of licensing, the carrier may require the insured to furnish at the patient's expense no less than ten and no more than thirty working days before treatment is to begin, an initial assessment of the need for chemical dependency treatment and a treatment plan, made by an individual of the patient's choice who is a qualified alcoholism and/or drug treatment counselor employed by an approved treatment facility under RCW 70.96A.020(2) or 69.54.030 or licensed under chapter 18.57 or 18.71 RCW to enable the carrier to make its own evaluation of medical necessity prior to scheduled treatment.

(6) Except as provided in this section, contractual provisions subject to this section and the administration

of such provisions shall not use definitions, predetermination procedures or other prior approval requirements, or other provisions, requirements or procedures, which unreasonably restrict access to treatment, continuity of care or payment of claims.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-050 (Order R 87-10), § 284-53-010, filed 8/31/87, effective 1/1/88; 86-18-027 (Order R 86-2), § 284-53-010, filed 8/27/86, effective 1/1/87.]

Chapter 284-54 WAC

LONG-TERM CARE INSURANCE RULES

WAC

284-54-010	Purpose and authority.
284-54-015	Applicability and scope.
284-54-020	Definitions of terms used in this chapter and chapter 48.84 RCW.
284-54-030	Standards for definitions applicable to long-term care contracts.
284-54-050	Exclusions.
284-54-100	Renewability.
284-54-150	Minimum standards—General.
284-54-160	Minimum standards—Gatekeeping provisions.
284-54-250	Grace period.
284-54-300	Information to be furnished, style.
284-54-350	Form to be used—Long-term care insurance disclosure form.
284-54-500	Format of long-term care contracts.
284-54-600	Loss ratio requirements.
284-54-610	Loss ratio definitions.
284-54-620	Loss ratio—Grouping of contract forms.
284-54-630	Loss ratio requirements—Individual contract forms.
284-54-650	Loss ratio experience records.
284-54-660	Evaluating loss ratio experience data.
284-54-680	Loss ratio—Special circumstances.
284-54-700	Advertising.
284-54-800	Unfair or deceptive acts.
284-54-900	Chapter not exclusive.

WAC 284-54-010 Purpose and authority. The purpose of this chapter, is to effectuate chapter 48.84 RCW, the Long-Term Care Insurance Act, by establishing minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care insurance and long-term care benefit policies and contracts.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-010, filed 7/9/87.]

WAC 284-54-015 Applicability and scope. (1) Except as otherwise specifically provided, this chapter shall apply to every policy, contract, or certificate, and riders pertaining thereto, of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, if such contract is primarily advertised, marketed, or designed to provide long-term care services over a prolonged period of time, which services may range from direct skilled medical care performed by trained medical professionals as prescribed by a physician or qualified case manager in consultation with the patient's attending physician to rehabilitative services and assistance with the basic necessary functions of daily living for people who have lost some or

complete capacity to function on their own. Such contract is "long-term care insurance" or a "long-term care contract," and is subject to this chapter.

(2) Pursuant to RCW 48.84.020, this chapter shall not apply to Medicare supplement insurance; nor shall it apply to a contract between a continuing care retirement community and its residents.

(3) Long-term care contracts not meeting the requirements of this chapter, may not be issued or delivered in this state after December 31, 1987.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-015, filed 7/9/87.]

WAC 284-54-020 Definitions of terms used in this chapter and chapter 48.84 RCW. For purposes of the administration of chapter 48.84 RCW and this chapter:

(1) "Community based care" means services provided outside an institutional setting and includes, but is not limited to, the following: (a) Home delivered nursing services or therapy; (b) custodial or personal care; (c) day care; (d) home and chore aid services; (e) nutritional services, both in-home and in a communal dining setting; and (f) respite care, whether provided at any level from skilled care to custodial or personal care.

(2) "Contract" means a long-term care insurance policy or contract, regardless of the kind of insurer issuing it, unless the context clearly indicates otherwise.

(3) "Direct response insurer" means an insurer who, as to a particular contract, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(4) A "gatekeeper provision" is any provision in a contract establishing a threshold requirement which must be satisfied before a covered person is eligible to receive benefits promised by the contract. Examples of such provisions include, but are not limited to the following: A three-day prior hospitalization requirement, recommendations of the attending physician, and recommendations of a case manager.

(5) "Institutional care" means care provided in a hospital, skilled or intermediate nursing home, congregate care facility, adult family home, or other facility certified or licensed by the state primarily affording diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services. Such a facility provides twenty-four-hour nursing services on its premises or in facilities available to the institution on a formal prearranged basis.

(6) "Insured" shall mean any beneficiary or owner of a long-term care contract regardless of the type of insurer.

(7) "Insurer" includes insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations unless the context clearly indicates otherwise.

(8) "Premium" shall mean all sums charged, received or deposited as consideration for a contract and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges as paid.

(9) "Terminally ill care" means care for an illness, disease, or injury which has reached a point where recovery can no longer be expected and the attending physician has certified that the patient is facing imminent death; or has a life expectancy of six months or less.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-020, filed 7/9/87.]

WAC 284-54-030 Standards for definitions applicable to long-term care contracts. The following definitions are applicable to long-term care contracts and the implementation of chapter 48.84 RCW and this chapter, and no contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which uses definitions more restrictive or less favorable to an insured than the following:

(1) "Acute care" means care provided for patients who are not medically stable. These patients require frequent monitoring by health care professionals in order to maintain their health status.

(2) "Benefit period" means the period of time for which the insured is eligible to receive benefits or services under a contract. A benefit period begins on the first day that the insured is eligible for and begins to receive the benefits of the contract. The benefit period ends when the insured is no longer eligible to receive benefits or has received the lifetime maximum benefits available. Such benefit period must be stated in terms of days rather than in terms of months of benefit.

(3) "Case manager" or "case coordinator" means an individual qualified by training and/or experience to coordinate the overall medical, personal and social service needs of the long-term care patient. Such coordination activities shall include but are not limited to: Assessing the individual's condition to determine what services and resources are necessary and by whom they might most appropriately be delivered; coordination of elements of a treatment or care plan and referral to the appropriate medical or social services personnel or agency; control coordination of patient services and continued monitoring of the patient to assess progress and assure that services are delivered. Such activities shall be conducted in consultation with the attending physician.

(4) "Chronic care" or "maintenance care" means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline. The care provided is usually for a long, drawn out or lingering disease or infirmity showing little change or slowly progressing with little likelihood of complete recovery, whether such care is provided in an institution or is community-based and whether such care requires skilled, intermediate or custodial/personal care.

(5) "Convalescent care" or "rehabilitative care" is nonacute care which is prescribed by a physician and is received during the period of recovery from an illness or injury when improvement can be anticipated, whether such care requires skilled, intermediate or custodial/personal care, and whether such care is provided in an institutional care facility or is community-based.

(6) "Custodial care" or "personal care" means care which is mainly for the purpose of meeting daily living

requirements. This level of care may be provided by persons without professional skills or training. Examples are: Help in walking, getting out of bed, bathing, dressing, eating, meal preparation, and taking medications. Such care is intended to maintain and support an existing level of health or to preserve the patient from further decline. Custodial or personal care services are those which may be recommended by the case manager in consultation with the patient's attending physician and are not primarily for the convenience of the insured or the insured's family.

(7) "Guaranteed renewable" means that renewal of a contract may not be declined by an insurer for any reason except for nonpayment of premium, but the insurer may revise rates on a class basis.

(8) A "home health aide" is a person who is providing care under the supervision of a physician, licensed professional nurse, physical therapist, occupational therapist, or speech therapist. Care provided may include ambulation and exercise, assistance with self-administered medications, reporting changes in a covered person's conditions and needs, completing appropriate records, and personal care or household services needed to achieve medically desired results.

(9) "Home care services" or "personal care services" are services of a personal nature including homemaker services, assistance with the activities of daily living, respite care services, or any other nonmedical services provided to ill, disabled, or infirm persons which services enable those persons to remain in their own residences consistent with their desires, abilities and safety.

(10) "Home health care" shall mean any of the following health or medical services: Nursing services, home health aide services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical or social services, and medical supplies or equipment services.

(11) "Intermediate care" means technical nursing care which requires selected nursing procedures for which the degree of care and evaluation is less than that provided for skilled care, but greater than that provided for custodial/personal care. This level of care provides a planned continuous program of nursing care that is preventive or rehabilitative in nature.

(12) "Long-term care total disability" means the functional inability due to illness, disease or infirmity to engage in the regular and customary activities of daily living which are usual for a person of the same age and sex.

(13) "Managed long-term care delivery system" means a system or network of providers arranged or controlled by a managed long-term care plan. Such systems provide a range of long-term care services with provisions for effective utilization controls and quality assurance. In the case of provision of long-term care in the managed care environment, a case manager or other qualified individual may be used to develop and coordinate a care plan of appropriate long-term care services.

(14) "Managed long-term care plan" means a plan which on a prepaid basis assumes the responsibility and

the risk for delivery of the covered long-term care services set forth in the benefit agreement. Actual services are rendered by the plan through its own staff, through capitation, or other contractual arrangements with providers. Managed long-term care plans may include but are not limited to those offered by health maintenance organizations, and health care service contractors, if their services are provided through a managed long-term care delivery system.

(15) "Noncancellable" means that renewal of a contract may not be declined except for nonpayment of premium, nor may rates be revised by the insurer.

(16) "One period of confinement" means consecutive days of institutional care received as an inpatient in a health care institution, or successive confinements due to the same or related causes when discharge from and readmission to the institution occurs within a period of time not more than ninety days or three times the maximum number of days of institutional care provided by the policy to a maximum of one hundred eighty days, whichever provides the covered person with the greater benefit.

(17) "Preexisting condition," as defined by RCW 48.84.020(3), means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

(18) "Respite care" is short-term care which is required in order to maintain the health or safety of the patient and to give temporary relief to the primary caretaker from his or her caretaking duties.

(19) "Skilled care" means care for an illness or injury which requires the training and skills of a licensed professional nurse, is prescribed by a physician, is medically necessary for the condition or illness of the patient, and is available on a twenty-four-hour basis.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-030, filed 7/9/87.]

WAC 284-54-050 Exclusions. No contract shall limit or exclude coverage by type of illness, accident, treatment, or medical condition, except with respect to the following:

(1) Conditions arising out of war or act of war (whether declared or undeclared);

(2) Conditions arising out of participation in the commission of a felony, riot or insurrection;

(3) Conditions resulting from suicide, attempted suicide (while sane or insane) or intentionally self-inflicted injury;

(4) Benefits available under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

(5) Services performed by a member of the covered person's immediate family;

(6) Services for which no charge is 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 and routine physical examinations;

(10) Chemical dependency;

(11) Treatment in a government hospital or in a government facility unless required by law;

(12) Benefits provided under Medicare or other governmental programs (except Medicaid);

(13) Experimental treatments, supplies, or services;

(14) Other exclusions appropriate to the particular contract, justified to the satisfaction of the commissioner, in connection with the filing of the contract form, may be permitted by prior written agreement.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-050, filed 7/9/87.]

WAC 284-54-100 Renewability. No insurer shall refuse to renew any long-term care contract or coverage thereunder: *Provided*, That after written approval of the commissioner, an insurer may discharge its obligation to renew by obtaining for the insured coverage with another insurer which coverage provides equivalent benefits for value paid.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-100, filed 7/9/87.]

WAC 284-54-150 Minimum standards--General. No contract may be advertised, solicited, or issued for delivery in this state as a long-term care contract which does not meet the following standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) No contract shall limit benefits to an unreasonable period of time or an unreasonable dollar amount. For example, a provision that a particular condition will be covered only for one year without regard to the actual amount of the benefits paid or provided, is not acceptable. Policies or contracts may, however, limit in-patient institutional care benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, as for example in the case of home health care visits, to a reasonable number of visits over a stated period of time.

(2) If a fixed-dollar indemnity, fee for services rendered or similar long-term care contract contains a maximum benefit period stated in terms of days for which benefits are paid or services are received by the insured, the days which are counted toward the benefit period must be days for which the insured has actually received one or more contract benefits or services. If benefits or services are not received on a given day, that day may not be counted. Waiver of premium shall not be considered a contract benefit for purposes of accrual of days under this section, and long-term care total disability shall not operate to reduce the benefit.

(3) If a contract of a managed health care plan contains a maximum benefit period it must be stated in terms of the days the insured is in the managed care delivery system. The days which are counted toward the benefit period may include days that the insured is under a care plan established by the case manager, or days in which the insured actually receives one or more benefits or services.

(4) Any nursing home or other institutional benefit must cover skilled, intermediate, and custodial or personal care.

(5) No contract may restrict or deny benefits because the insured has failed to meet medicare beneficiary eligibility criteria.

(6) If an insurer offers a contract form which requires entrance to an institution at the skilled care level, it must also offer an otherwise identical contract form offering benefits without such a requirement.

(7) If an insurer offers a contract form which requires prior hospitalization, it must also offer an otherwise identical contract form without such a requirement.

(8) No long-term care contract may restrict benefit payments to a requirement that the patient is making a "steady improvement" or limit benefits to "recuperation" of health.

(9) All long-term care contracts shall be issued as individual or family contracts only, unless coverage is provided pursuant to a group contract, issued to a bona fide group, which contract provides continuity of coverage equivalent to that which would be provided under a guaranteed renewable individual contract, and otherwise satisfies the commissioner that it is not contrary to the best interests of the public.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-150, filed 7/9/87.]

WAC 284-54-160 Minimum standards-- Gatekeeping provisions. Any gatekeeper provisions must be reasonable in relation to the benefits promised in the contract. It must be demonstrated to the satisfaction of the commissioner that a reasonable number of insureds who can be expected to receive benefit or contract payments because of an illness, injury or condition, are not precluded by the gatekeeper from receiving said benefits. Policies or contracts providing long-term care benefits following institutionalization shall not condition such benefits upon admission to the long-term care facility within a period of fewer than thirty days after discharge from the institution.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-160, filed 7/9/87.]

WAC 284-54-250 Grace period. Every long-term care contract must contain a grace period of no fewer than thirty-one days following the due date for the payment of premiums.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-250, filed 7/9/87.]

WAC 284-54-300 Information to be furnished, style. (1) Each broker, agent, or other representative of an insurer selling or offering benefits that are designed, or represented as being designed, to provide long-term care insurance benefits, shall deliver the disclosure form as set forth in WAC 284-54-350 not later than the time of application for the contract. If an agent has solicited the coverage, the disclosure form shall be signed by that agent and a copy left with the applicant. The insurer shall maintain a copy in its files.

(2) The disclosure form required by this section shall identify the insurer issuing the contract and may contain additional appropriate information in the heading. The informational portion of the form shall be substantially as set forth in WAC 284-54-350 and words emphasized therein shall be underlined or otherwise emphasized in each form issued. The form shall be printed in a style and with a type character that is easily read by an average person eligible for long-term care insurance.

(3) Where inappropriate terms are used in the disclosure form, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization shall substitute appropriate terminology.

(4) In completing the form, each subsection shall contain information which succinctly and fairly informs the purchaser as to the contents or coverage in the contract. If the contract provides no coverage with respect to the item, that shall be so stated. Address each of the questions as though they had been raised by the applicant regarding a long-term care policy. Address the answer to the reasonable person likely to purchase long-term care insurance.

(5) A policy which provides for the payment of benefits based on standards described as "usual," "customary," or "reasonable" (or any combination thereof), or words of similar import, shall include an explanation of such terms in its disclosure form and in the definitions section of the contract.

(6) If the contract contains any gatekeeper provision which limits benefits or precludes the insured from receiving benefits, such gatekeeper provision must be fully described.

(7) All insurers shall use the same disclosure form. It is intended that the information provided in the disclosure form will appear in substantially the same format provided to enable a purchaser to compare competing contracts easily.

(8) The information provided shall include the statement: "This is NOT a Medicare supplement policy," and shall otherwise comply with WAC 284-55-067.

(9) The required disclosure form must be filed by the insurer with the commissioner prior to use in this state.

(10) In any case where the prescribed disclosure form is inappropriate for the coverage provided by the contract, an alternate disclosure form shall be submitted to the commissioner for prior approval or acceptance.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-300, filed 7/9/87.]

WAC 284-54-350 Form to be used--Long-term care insurance disclosure form. The following disclosure form shall be used:

(Company Name)
Disclosure Form
Long-term Care Insurance

The decision to buy a new long-term care policy is very important. It should be carefully considered.

The following data give you some general tips and furnish you with a summary of benefits available under our policy.

Your long-term care policy provides thirty days (sixty days for direct response insurers) within which you may decide without cost whether you wish to keep it. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available under your policy.

If you now have insurance which provides benefits for long-term care, read your policy carefully. Look for what is said about renewing it. See if it contains waiting periods before benefits are paid. Note how it covers pre-existing conditions (health conditions you already have).

Compare these features with similar ones in any new policy. Use this information to measure the value of any insurance or health care plans you now have.

DON'T BUY MORE INSURANCE THAN YOU REALLY NEED. One policy that meets your needs is usually less expensive than several limited policies.

If you are eligible for state medical assistance coupons (Medicaid), you should not purchase a long-term care insurance policy.

After you receive your policy, make sure you have received the coverage you thought you bought. If you are not satisfied with the policy, you may return it within thirty days (sixty days for direct response insurer) for a full refund of premium.

DISCLOSURE FORM

BENEFITS PROVIDED UNDER THE CONTRACT

Level of Care: Location Given:	Skilled Care		Intermediate Care		Custodial/Personal Care	
	Nursing Home	Home-Based	Nursing Home	Home-Based	Nursing Home	Home-Based
Payment Per Day	\$/% _____	\$/% _____	\$/% _____	\$/% _____	\$/% _____	\$/% _____
Number of Days of Benefits:	_____	_____	_____	_____	_____	_____

GENERAL CONTRACT INFORMATION

Premium	Waiver of Premium	Recurring Conditions	Maximum Lifetime Benefits	Restoration of Maximum Lifetime Benefits?
Do premiums remain unchanged for life? Yes/No	Must premiums be paid when you are receiving benefits? Yes/No	If your disability recurs, when do you have to: -satisfy a new waiting period? -pay a new deductible? Explain: _____	Days _____ Dollars _____	Yes/No If yes, explain how and when they will be restored: _____
Will premiums automatically increase with age? Yes/No	Explain: _____	Explain: _____	_____	_____
May the company make additional premium increases? Explain: _____	_____	_____	_____	_____

LIMITATIONS ON COVERAGE

Exclusions and Exceptions (List and Explain Carefully)	Pre-Existing Conditions	Restrictions on Where and From Whom Care Received?	Payments You Must Make When You Have A Claim (List, Explain)
How many days do you have to wait to collect benefits: - after the policy is effective? - after you become ill: Other significant exclusions: _____	Are conditions for which you have been created: -excluded? -limited? Treatment how long ago? Excluded how long? _____	Yes/No If yes, Explain: _____	Amount of co-payment charge: _____ Deductible: _____ Other: _____

NURSING HOME OR OTHER IN-PATIENT BENEFITS

Number of Days of Prior Hospitalization Required	Max. No. of Days Between Hospital Discharge and Nursing Home Admission	Level of Care Required at Time of Nursing Home Admission	No. of Days of Skilled Care Required to Qualify for Another Level of Care	Maximum Nursing Home or In-Patient Benefits
_____	_____	_____	_____	Days? _____ Dollars? _____

HOME-BASED OR OTHER OUT-PATIENT CARE BENEFITS

Covered Services (State whether covered and briefly explain limitations on benefits)	Gatekeeping (Threshold) Requirements	Maximum Home or Out-Patient Benefits
Hygiene/Personal Care? _____	Prior in-patient care required? Yes/No _____	Maximum number of days or visits: _____
Chore Services? _____	Prior level of in-patient care required? _____	Maximum duration of visits: _____
Meals/Nutritional Services? _____	Assessment by case manager or other required? Yes/No _____	Dollar Maximum: _____
Respite Care? _____	Explain: _____	_____
Adult Day Care? _____	_____	_____
Durable Medical Equipment? _____	_____	_____

SPECIAL COVERAGE OR LIMITATIONS: _____

=====

Premium: _____ Mode: _____

*This disclosure form was delivered to me on: _____ (date)

* _____
(Signature of Applicant)

*By: _____

*(Agent or Broker -- printed name and signature)

Contract Form No. _____

* A direct response insurer need not include this portion of the disclosure form.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-350, filed 7/9/87.]

WAC 284-54-500 Format of long-term care contracts. No long-term care contract shall be delivered or issued for delivery to any person in this state if it fails to comply with the following:

(1) The style, arrangement, and over-all appearance of the policy shall give no undue prominence to any portion of the text (except as required by this chapter). Every printed portion of the text of the contract and of any amendment or attached papers shall be plainly printed in easily read type.

(2) Limitations, exclusions, exceptions, and reductions of coverage or benefits shall be set forth in the policy and shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "LIMITATIONS and EXCEPTIONS," or "EXCLUSIONS and REDUCTIONS," except that if a limitation, exclusion, exception, or reduction specifically applies only to a particular benefit of the policy, a statement of such limitation, exclusion, exception, or reduction shall be included with the benefit provision to which it applies.

(3) Each contract delivered or issued for delivery to any person in this state shall clearly indicate on its first page that it is a "LONG-TERM CARE INSURANCE" contract. In addition, the contract shall contain a table of contents which shall clearly identify the location within the contract of each of the provisions of the contract with particular attention to the location of contract provisions for (a) limitations, exclusions, exceptions or reductions of coverage, (b) renewability, (c) definitions, (d) gatekeeping provisions, and (e) any unique provisions or circumstances such as elimination periods, or minimum or maximum limits. The term "contract" or "certificate" may be substituted on the first page of the contract for the word "insurance" where appropriate.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-500, filed 7/9/87.]

WAC 284-54-600 Loss ratio requirements. (1) The provisions of chapter 284-60 WAC shall apply to every contract of long-term care issued by a disability insurer and fraternal benefit society. The provisions of WAC 284-54-610 through 284-54-680 shall apply to every long-term care contract issued by a health care service contractor or health maintenance organization.

(2) Benefits for all long-term care contracts shall be reasonable in relation to the premium or price charged.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-600, filed 7/9/87.]

WAC 284-54-610 Loss ratio definitions. The following definitions apply to WAC 284-54-610 through 284-54-680:

(1) "Loss ratio" means the claims incurred plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

(2) "Claims" shall mean the cost of health care services paid to or provided on behalf of covered individuals

in accordance with the terms of contracts issued by health care service contractors or health maintenance organizations or capitation payments made to providers of long-term care.

(3) The "expected loss ratio" is a prospective calculation and shall be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and shall be based on the pricing actuary's best projections of the future experience within the "calculating period."

(4) The "actual loss ratio" is a retrospective calculation and shall be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

(5) The "overall loss ratio" shall be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

(6) The "calculating period" shall be the time span over which the pricing actuary expects the premium rates whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the pricing actuary does not expect to request a rate increase.

(7) The "benefits incurred" shall be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

(8) The "claims incurred" shall mean:

(a) Claims paid during the accounting period; plus

(b) The change in the liability for claims which have been reported but not paid; plus

(c) The change in the liability for claims which have not been reported but which may reasonably be expected.

The "claims incurred" shall not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

(9) The "reserves," as referred to in this section, shall include:

(a) Active life disability reserves;

(b) Additional reserves whether for a specific liability purpose or not;

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

(e) Increased reserves which may be required by the commissioner.

(10) The "premiums earned" shall mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-610, filed 7/9/87.]

WAC 284-54-620 Loss ratio—Grouping of contract forms. For purposes of rate making and requests for rate increase.

(1) The actuary responsible for setting premium rates shall group similar contract forms, including forms no longer being marketed if issued on or after January 1,

1988, in the pricing calculations. Such grouping shall rely on the judgment of the pricing actuary and be satisfactory to the commissioner. Among the factors which shall be considered are similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between contract holders. Such grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.44.220 or 48.46.370.

(2) The insureds under similar contract forms are grouped at the time of rate making in accord with RCW 48.44.220 or 48.46.370 because they are expected to have substantially like insuring, risk and exposure factors and expense elements. The morbidity and mortality experience of these insureds will, as a group, deteriorate over time. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3) to withdraw a form from its assigned grouping by reason of the deteriorating health of the insureds covered thereunder.

(3) One or more of the contract forms grouped for rate making purposes may, by random chance, experience significantly higher or more frequent claims than the other forms. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370, to deviate from the assigned grouping of contract forms for pricing purposes at the time of requesting a rate increase unless the pricing actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

(4) Successive contract forms of similar benefits are sometimes introduced by health care service contractors and health maintenance organizations for the purpose of keeping up with trends in hospital costs, new developments in medical practice, additional supplemental benefits offered by competitors, and other reasons. While this is commendable, contract holders who can not qualify for the new improved contracts, or to whom the new benefits are not offered, are left isolated as a high risk group under the prior form and soon become subject to massive rate increases. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3), to fail to combine successive generic contract forms and to fail to combine contract forms of similar benefits covering generations of contract holders in the calculation of premium rate and loss ratios.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-620, filed 7/9/87.]

WAC 284-54-630 Loss ratio requirements--Individual contract forms. The following standards and requirements apply to individual contract forms:

(1) Benefits shall be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the health

care service contractor or health maintenance organization which calculating period is satisfactory to the commissioner.

(2) The calculating period may vary with the benefit and renewal provisions. The health care service contractor or health maintenance organization may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period shall accompany the filing.

(3) Contract forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, shall use a relatively short calculating period reflecting the uncertainties of estimating the risks involved. Contract forms based on more dependable statistics may employ a longer calculating period. The calculating period may be the lifetime of the contract for guaranteed renewable and noncancellable contract forms if such forms provide benefits which are supported by reliable statistics and which are protected from inflationary or eroding forces by such factors as fixed dollar coverage, inside benefit limits, or the inherent nature of the benefits. The calculating period may be as short as one year for coverage which are based on statistics of minimal reliability or which are highly exposed to inflation.

(4) A request for a rate increase to be effective at the end of the calculating period shall include a comparison of the actual to the expected loss ratios, shall employ any accumulation of reserves in the determination of rates for the new calculating period, and shall account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

(5) A request for a rate increase submitted during the calculation period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

(6) The commissioner may accept a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and antiselection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or for a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

(7) Health care service contractors and health maintenance organizations shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-630, filed 7/9/87.]

WAC 284-54-650 Loss ratio experience records. Health care service contractors and health maintenance organizations shall maintain records of earned premiums and incurred benefits for each contract year for each contract, rider, endorsement, amendment and similar form which were combined for purposes of premium calculations, including the reserves. Records shall also be maintained of the experience expected in the premium calculations. Notwithstanding the foregoing, with proper justification, the commissioner may accept approximation of contract year experience based on calendar year data.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-650, filed 7/9/87.]

WAC 284-54-660 Evaluating loss ratio experience data. In determining the credibility and appropriateness of experience data, due consideration shall be given to all relevant factors including:

- (1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;
- (2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, inflation in expense charges and others;
- (3) The concentration of experience at early contract durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later contract durations;
- (4) The mix of business by risk classification;
- (5) The expected lapses and antiselection at the time of rate increases.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-660, filed 7/9/87.]

WAC 284-54-680 Loss ratio--Special circumstances. Loss ratios other than those indicated in WAC 284-54-630 may be approved by the commissioner with satisfactory actuarial demonstrations. Examples of coverage where the commissioner may grant special considerations are:

- (1) Contract forms exposed to high risk of claim fluctuation because of the low loss frequency, or the catastrophic or experimental nature of the coverage.
- (2) Individual situations where higher than usual expenses are expected because of peculiar administrative or geographic circumstances.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-680, filed 7/9/87.]

WAC 284-54-700 Advertising. In addition to this chapter, specific applicable standards for the regulation of advertisements relating to individual, group, blanket, and franchise and individual and group health care service contractors' agreements, are included in WAC 284-50-010 through 284-50-230, and are applicable to the advertisement of all long-term care insurance contracts.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-700, filed 7/9/87.]

WAC 284-54-800 Unfair or deceptive acts. RCW 48.84.910 authorizes the commissioner to prohibit particular unfair or deceptive acts in the conduct of the advertising, sale, and marketing of long-term care policies and contracts. The purpose of this section is to define certain minimum standards which insurers should meet with respect to long-term care. If the following standards are violated with such frequency as to indicate a general business practice by an insurer, it will be deemed to constitute an unfair method of competition or a deceptive act by such insurer and a violation of this section.

- (1) Misrepresenting pertinent facts or insurance contract provisions.
- (2) Failing to acknowledge and act reasonably promptly upon communications with respect to communications arising under insurance policies or contracts.
- (3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies or contracts.
- (4) Refusing to pay claims or provide benefits without conducting a reasonable investigation.
- (5) Failing to affirm or deny coverage of claims within a reasonable time.
- (6) Compelling an insured to institute litigation to recover amounts due under an insurance contract by offering substantially less than the amounts ultimately recovered in actions brought by such an insured.
- (7) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (8) Making claims payments to an insured or beneficiaries not accompanied by an explanation setting forth the coverage under which the payments are being made.
- (9) Failing to promptly provide a reasonable explanation of the basis in the insurance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
- (10) Asserting to an insured or claimant a policy of appealing from arbitration awards in favor of an insured or claimant for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
- (11) Delaying the investigation or payment of claims by unreasonably requiring an insured, claimant, or the attending physician of the patient to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.
- (12) Failure to expeditiously honor drafts given in settlement of claims within three working days of notice of receipt by the payor bank except for reasons acceptable to the commissioner.
- (13) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.
- (14) Issue checks or drafts in partial payment of a loss or claim under a specific coverage which contain

language which appear to release the insurer from its total liability.

(15) Failure to reply to the insurance commissioner within fifteen working days of receipt of an inquiry, such reply to furnish the commissioner with an adequate response to the inquiry.

(16) Failure to settle a claim on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions as permitted by this chapter.

(17) Making statements which indicate the rights of persons may be impaired if a form or release is not completed within a given time unless the statement otherwise is provided by policy provisions or is for the purpose of notifying that person of the provisions of an applicable statute of limitations.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-800, filed 7/9/87.]

WAC 284-54-900 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate a long-term care contract under other sections of Title 48 RCW.

[Statutory Authority: RCW 48.02.060(3), 48.30.010 and 48.84.910. 87-15-027 (Order R 87-7), § 284-54-900, filed 7/9/87.]

**Chapter 284-55 WAC
MEDICARE SUPPLEMENTAL HEALTH
INSURANCE REGULATION**

WAC

284-55-010	Purpose.
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284-55-180	Requirements for advertising.
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284-55-190 Chapter not exclusive.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-55-100	Return of certificate for refund, unfair practice. [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.] Repealed by 88-22-061 (Order R 88-9), filed 11/1/88. Statutory Authority: RCW 48-.02.060 (3)(a) and 48.30.010(2).
284-55-110	Loss ratio requirements. [Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-110, 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.] Repealed by 88-22-061 (Order R 88-9), filed 11/1/88. Statutory Authority: RCW 48-.02.060 (3)(a) and 48.30.010(2).

WAC 284-55-010 Purpose. The purpose of this regulation, chapter 284-55 WAC, 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; to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program; to provide for the reasonable standardization of the coverage, terms, and benefits of Medicare supplement insurance policies; to eliminate policy provisions which may duplicate Medicare benefits; and to provide for refunds of premiums associated with benefits duplicating Medicare benefits.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-010, filed 11/1/88. 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) Except as required by federal law, 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 RCW 48.66.160, to the extent they may be in conflict with this regulation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-020, filed 11/1/88. 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 insurance companies, 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 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-030, filed 11/1/88. 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 treatment of chemical dependency; 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 Health Care Organizations.

(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 48.02.060 (3)(a) and 48.30.010(2), 88-22-061 (Order R 88-9), § 284-55-035, filed 11/1/88. 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 Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(3) 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 and chemical dependency;

(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, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

(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.

(4) 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.

(5) 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.

(6) No Medicare supplement insurance policy shall restrict, exclude or limit benefits for a sickness through use of a probationary, or similar, provision.

(7) No insurer shall require any person covered under a Medicare supplement insurance policy to purchase additional coverage in connection with the amendment thereof.

(8) The terms "Medicare supplement," "Medigap," or words of similar import shall not be used to describe an insurance policy or contract unless such policy or contract is issued in compliance with chapter 48.66 RCW and this chapter.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-040, filed 11/1/88. 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(3), 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. Except in subsection (1) of this section which requires fixed benefits, these are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

(2) Coverage for the daily copayment amount of Medicare Part A eligible expenses for the first eight days per calendar year incurred for skilled nursing facility care.

(3) Coverage for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Medicare Part A not replaced in accordance with federal regulations.

(4)(a) Until January 1, 1990, 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.

(b) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses (excluding outpatient prescription drugs) under Medicare Part B up to the maximum out-of-pocket amount for Medicare Part B after the Medicare deductible amount.

(5) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under Medicare Part B not replaced in accordance with federal regulations.

(6) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses for covered home intravenous (IV) therapy drugs (as determined by the Secretary of Health and Human Services) subject to the Medicare outpatient prescription drug deductible amount, if applicable.

(7) Effective January 1, 1990, coverage for the copayment amount of Medicare eligible expenses for outpatient drugs used in immunosuppressive therapy subject to the Medicare outpatient prescription drug deductible, if applicable.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-045, filed 11/1/88. 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. (1)

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.

(2) The disclosure form to be used shall be the "outline of coverage," which is set forth in WAC 284-55-060.

(3) Except for direct response insurers, an insurer shall obtain an acknowledgement of receipt of such outline from the applicant.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-050, filed 11/1/88. 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 description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	THIS POLICY PAYS	YOU PAY
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I. Part A

A. INPATIENT HOSPITAL SERVICES:

Semi-private room & board

Miscellaneous hospital services & supplies, such as drugs, X-rays, lab tests & operating room

B. SKILLED NURSING CARE

C. BLOOD

II. Part B

A. MEDICAL EXPENSE:

Services of a physician/ outpatient services

Medical supplies other than prescribed drugs

SERVICE	THIS POLICY PAYS	YOU PAY
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B. BLOOD

C. MAMMOGRAPHY SCREENING

D. OUT-OF-POCKET MAXIMUM

E. PRESCRIPTION DRUGS

III. Parts A & B

Home health services

IV. Miscellaneous

A. Home intravenous (IV) therapy drugs

B. Immunosuppressive drugs

C. Respite care benefits

IN ADDITION TO THIS OUTLINE OF COVERAGE, (INSURANCE COMPANY NAME) WILL SEND AN ANNUAL NOTICE TO YOU THIRTY DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

(5) (The following charts shall accompany the outline of coverage:)

Part A
 MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PART A				
Inpatient Hospital Services:	All but \$540 for first 60 days/benefit period	All but [\$564] deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year
Semi-Private Room & Board	All but \$135 a day for 61st-90th days/benefit period			
Miscellaneous Hospital Services & Supplies, such as Drugs, X-rays, Lab Tests & Operating Room	All but \$270 a day for 91st-150th days (if the individual chooses to use 60 nonrenewable lifetime reserve days)			
	Nothing beyond 150 days			

Skilled Nursing Facility Care	100% of costs for 1st 20 days (after a 3 day prior hospital confinement) All but \$67.50 a day for 1st-100th days Nothing beyond 100 days	80% of Medicare reasonable costs for first 8 days per calendar year w/out prior hospitalization requirement 100% of costs thereafter up to 150 days/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year

Blood	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> . Part A blood deductible reduced to the extent paid under Part B	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)

Part B
MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Parts A & B:				
Home Health Services	Intermittent skilled nursing care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases)--100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as '88	Intermittent skilled nursing care for up to 7 days a week for up to 38 days allowing for continuation of services under unusual circumstances; other services, --100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as '90

PART B

Medical Expense: Services of a Physician/Outpatient Services	80% of reasonable charges after an annual \$75 deductible	80% after annual \$75 deductible	80% of reasonable charges after \$75 annual deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for remainder of calendar year	Same as '90
Medical Supplies Other than Prescribed Drugs				

Blood	80% of costs except nonreplacement fees (blood deductible) for 1st 3 pints in each benefit period after \$75 deductible	Pays 80% of all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u>	Same as '89	Same as '89
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Mammography Screening			80% of approved charge for elderly and disabled Medicare beneficiaries - exams available every other year for women 65 & over	Same as '90
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Out-of-Pocket Maximum			\$1,370 consisting of Part B \$75 deductible, Part B blood deductible and 20% co-insurance	\$1,370-will be adjusted annually by Secretary of Health and Human Services
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Outpatient Prescription Drugs			There is a \$550 total deductible applicable to home IV drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% co-insurance
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Part B
 MEDICARE BENEFITS IN
 (cont'd)

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
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PART B

Home IV- Drug Therapy			80% of IV therapy drugs subject to \$550 deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)	80% of IV therapy drugs subject to standard drug deductible (deductible waived if home therapy is a continuation of therapy drugs initiated in a hospital)
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Immunosuppressive Drug Therapy	80% of costs during 1st year following a covered organ transplant (no special drug deductible; only the regular Part B deductible)	Same as '88	Same as '88 for 1st year following covered transplant; 50% of costs during 2nd and following years (subject to \$550 deductible)	Same as '90 (subject to \$600 deductible)
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Respite Care Benefit			In-home care for chronically dependent individual covered for up to 80 hours after either the out-of-pocket limit or the outpatient drug deductible has been met	Same as '90
-------------------------	--	--	--	-------------

- (6) (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 and insulin (other than prescription drugs furnished during a hospital or skilled nursing facility stay),
 - (h) Care received outside of U.S.A. (and its territories),
 - (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for, or the cost of, eyeglasses or hearing aids.

- (7) (An explanation of such terms as "usual and customary," "reasonable and customary," or words of similar import, if used in the policy.)
- (8) 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 subsection (4) of this section, 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.
- (9) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.
- (10) The amount of premium for this policy.

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

 (Agent's or Officer's Signature)

(Drafting note. Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization shall substitute appropriate terminology.)

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-060, filed 11/1/88. 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 Buyer's guide. (1) 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."

(2) 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.

(3) 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 insurance 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 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-065, filed 11/1/88. 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, comprehensive, 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 insurance 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 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-067, filed 11/1/88. 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 insurance 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 insurance 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 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-070, filed 11/1/88. 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. Federal and state law provides thirty 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 pre-existing 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 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-080, filed 11/1/88. 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. Federal and state law provides thirty 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 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 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-090, filed 11/1/88. 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 284-55-095 Prohibited compensation for replacement with the same insurer. No insurer shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing Medicare supplement insurance policy if an existing Medicare supplement insurance policy is replaced by another such policy where the new benefits are substantially similar to the benefits under the old Medicare supplement insurance policy and such old policy was issued by the same insurer or insurer group.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-095, filed 11/1/88.]

WAC 284-55-100 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-55-110 Repealed. See Disposition Table at beginning of this chapter.

WAC 284-55-115 Standards for loss ratios. (1) Medicare supplement insurance policies shall return to policyholders in the form of aggregated benefits under such policy, for the entire period for which rates are computed to provide coverage, loss ratios not less than those set forth in this section. Such aggregated benefits shall be on the basis of incurred claims experience and earned premiums for such period in accordance with accepted actuarial principles. The loss ratio standards of this section are more stringent and more appropriate than those imposed by RCW 48.66.100, and are necessary for the protection of the public interest. Where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, such aggregated benefits shall be on the basis of incurred health care expenses and earned premiums for such period.

(2) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this chapter.

(3) Every insurer providing Medicare supplement policies in this state shall annually file its rates, rating schedules, and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience. Supporting documentation shall include the amounts of unearned premium reserve, additional policy reserves, and claim reserves and liabilities, both nationally and for this state.

(4) Incurred losses shall include claims paid and the change in claim reserves and liabilities. Incurred losses shall not include policy reserves, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, profit, or claims processing costs.

(5) The following criteria will be used to determine whether policy forms are in compliance with the loss ratio standards of this section:

(a) For the most recent year, the ratio of the incurred losses to earned premiums is greater than or equal to the applicable percentages contained in this section; and

(b) The expected losses in relation to premiums over the entire period for which the policy is rated complies with the requirements of this section, relying on the judgment of the pricing actuary and acceptable to the commissioner; and

(c) An expected third-year loss ratio, greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years.

(d) Similar policy forms shall be grouped together according to the rules set forth in WAC 284-60-040.

(e) The commissioner may consider additional criteria including, but not limited to:

(i) Equitable treatment of policyholders; and
(ii) The amount of policy reserves as defined for the insurer's statutory annual statement.

(6) Medicare supplement insurance policies issued by disability insurers and fraternal benefit societies shall be expected to return to a policyholder in the form of aggregated loss ratios under the policy, at least sixty-five percent of the earned premiums in the case of individual policies, and seventy-five percent in the case of group policies.

(7) The minimum anticipated loss ratio requirement for health care service contractors shall be seventy percent for individual forms and eighty percent for group contract forms.

(8)(a) The minimum anticipated loss ratios for a health maintenance organization are deemed to be met if its health care expense costs are seventy percent or more of the earned premium charged individual subscribers, or eighty percent or more of the earned premium charged subscribers covered under a group contract.

(b) For purposes of this chapter, "health care expense costs" means expenses of a health maintenance organization associated with the delivery of health care services which are analogous to incurred losses of insurers. Such expenses shall not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs and "claims" processing costs.

(9) For purposes of this chapter, "premium" means 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.

(10) For purposes of this chapter, "earned premium" shall mean the "premium" applicable to an accounting period whether received before, during, or after such period.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-115, filed 11/1/88.]

WAC 284-55-120 Attained age rating prohibited. Effective January 1, 1989, with respect to Medicare supplement insurance policies initially sold to residents of this state on or after that date, it is an unfair practice and an unfair method of competition for any insurer, and a prohibited practice for any health care service contractor or health maintenance organization, to use the increasing age of an insured, subscriber, or participant as the basis for increasing premiums or prepayment charges.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-120, filed 11/1/88.]

WAC 284-55-125 Riders and endorsements. (1) In order to assure the orderly implementation and conversion of Medicare supplement insurance benefits due to changes in the federal Medicare program and to eliminate provisions which may duplicate Medicare:

(a) No later than January 1, 1990, all insurers must substitute new policies for all Medicare supplement insurance policies or contracts sold to residents of this state prior to January 1, 1990, where policies were amended by riders or endorsements to comply with changes to Medicare.

(b) Effective January 1, 1990, subject to RCW 48.66.050(2), and except for riders or endorsements issued in accordance with subsection (2) of this section, no rider, endorsement, waiver, or any other means of contractual modification may be used by an insurer to exclude, limit, or reduce the coverage or benefits of a Medicare supplement insurance policy issued to a resident of this state.

(2)(a) Effective January 1, 1990, only riders or endorsements which increase benefits or coverage may be used in this state.

(b) A Medicare supplement insurance policy amendment which increases the premium must be requested or accepted by the insured in writing.

(c) Where separate additional premium is charged for a Medicare supplement insurance policy rider, endorsement or other amendment thereto, such premium charge shall be set forth in the policy.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-125, filed 11/1/88.]

WAC 284-55-130 Substitution of policies. Each Washington resident insured under a Medicare supplement insurance policy, whether individual or group, issued prior to January 1, 1990, and modified by a rider, endorsement or waiver, shall receive a substitution policy or certificate which meets all of the following requirements and which has been approved by the commissioner in accordance with the provisions of this chapter. Substitution certificates shall be provided to members of groups after the necessary changes have been made to the master contract.

(1) Each insured must be guaranteed a "roll-over" from an existing Medicare supplement insurance policy to a substitution policy, and except for benefits that duplicate Medicare, such substitution policy shall contain benefits that are at least as favorable to the insured as the benefits provided by the insured's prior policy.

(2) Premiums for the substitution policy must be determined on the same basis as the insured's policy immediately prior to the substitution.

(3) Where the insured has already satisfied any waiting or exclusionary period under a prior Medicare supplement insurance policy, the substitution policy may not require a new waiting period, a new preexisting condition limitation, or any other provision which would have the effect of limiting benefits.

(4) No insurer shall require an insured to purchase additional coverage or benefits in connection with the roll-over to a substitution policy.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-130, filed 11/1/88.]

WAC 284-55-150 Filing requirements and premium adjustments. (1) For Medicare supplement insurance

policy forms initially sold to residents of this state on or after January 1, 1989:

(a) Within ninety days of the effective date of this rule, every insurer required to file its Medicare supplement insurance policy forms with the commissioner shall file with the commissioner new Medicare supplement insurance policy forms which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare and which provide a clear description of the policy or contract benefit; and

(b) The filing required under this subsection shall provide for loss ratios which are at least as favorable to the insured as the minimum loss ratio standards established by WAC 284-55-115.

(2) Annually, beginning with changes to be effective January 1, 1990, as soon as practicable, but not less than sixty days prior to the annual effective date of the changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer providing Medicare supplement insurance policies in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(a) Policy forms necessary to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare, such forms providing a clear description of the Medicare supplement benefits provided by the policy or contract; and

(b) Appropriate premium adjustments necessary to produce complying loss ratios originally anticipated for the applicable policies or contracts and such supporting documents necessary in the opinion of the commissioner to justify the adjustments.

(3) Every insurer providing Medicare supplement insurance or benefits to a resident of this state shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with the minimum loss ratio standards of WAC 284-55-115.

(4) No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described in this section, may be made with respect to a policy at any time other than upon its renewal or anniversary date.

(5) Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty days of the renewal or anniversary date if a refund is provided to the premium payer.

(6) For purposes of rate making and requests for rate increases, all individual Medicare supplement policy forms of an insurer are considered "similar policy forms" including forms no longer being marketed.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-150, filed 11/1/88.]

WAC 284-55-155 Filing requirements for out-of-state group policies. Every insurer providing group Medicare supplement insurance benefits to a resident of this state shall, within thirty days of its use in this state, file with the commissioner a copy of the master policy and any certificate used in this state.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-155, filed 11/1/88.]

WAC 284-55-160 Annual adjustment notice to conform existing Medicare supplement policies to Medicare changes. No later than thirty days prior to the annual effective date of changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer providing Medicare supplement insurance policies to a resident of this state shall notify its insureds of modifications it has made to Medicare supplement insurance policies in an annual adjustment notice. For the years 1989 and 1990, and in 1990 only if outpatient prescription drugs are covered by the policy or contract, such notice shall be substantially in the format prescribed by the commissioner at WAC 284-55-165 through 284-55-175. The annual adjustment notice is intended to be informational only and for the sole purpose of informing policy and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like.

(1) Such notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy.

(2) Such notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be made.

(3) Such annual adjustment notice of benefit modifications and any premium adjustment shall be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) Such notice shall not contain or be accompanied by any solicitation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-160, filed 11/1/88.]

WAC 284-55-165 Form of annual adjustment notice--Policy changes effective January 1, 1989.

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE -- 1989

Your health care benefits provided by the federal Medicare program will change beginning January 1, 1989. Additional change will occur on medical benefits in following years. The major changes are summarized below. These changes will affect hospital, medical and other services and supplies provided under Medicare. Because of these changes your Medicare supplement coverage provided by _____(company name)_____ will change, also. The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format.)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

Medicare Now	Effective January 1, 1989 Medicare Will	Your 1988 Coverage	Effective Jan. 1, 1989 Your Coverage
Pays Per	Pay Per Calendar	Per Benefit	Will Pay Per
Benefit Period	Year	Period	Calendar Year

MEDICARE PART A: SERVICES AND SUPPLIES

First 60 days - Unlimited number of
all but hospital days after
\$540 \$564 deductible

61st to 90th
day - all but
\$135/day

91st to 150th
day - all but
\$270/day (if
individual chooses
to use 60 nonrenewable
lifetime days)

Beyond 150th day
-- nothing

(Chart continued - For Use in 1989)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT
COVERAGE

Medicare Now Pays Per Benefit Period	Effective January 1, 1989 Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective Jan. 1, 1989 Your Coverage Will Pay Per Calendar Year
--	--	--	--

SKILLED NURSING FACILITY CARE

Requires a 3-day prior stay and enter the facility generally within 30 days after hospital discharge	There is no prior confinement requirement for this benefit		
First 20 days - 100% of costs	First 8 days - All but \$(_22.00_) a day		
21st through 100th day - all but \$67.50 a day	9th through 150th 100% of costs		
Beyond 100 days - Nothing	Beyond 150 days - Nothing		

MEDICARE PART B: SERVICES AND SUPPLIES

80% of allowable charges (after \$75.00 deductible)	In 1989 Medicare Part B pays the same as in 1989
---	--

NOTE: Medicare Benefits changes
on January 1, 1990 as follows:

80% of allowable charges (after
\$75.00 deductible) until an annual
Medicare Catastrophic Limit is
met. 100% of allowable charges
for the remainder of the calendar
year. The limit in 1990 is \$1370 *
and will be adjusted on an annual
basis.

* Expenses that count toward the Part B Medicare Catastrophic Limit include:
the Part B deductible and copayment charges and the Part B blood deductible
charges.

(Chart continued - For Use in 1989)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT
COVERAGE

Medicare Now Pays Per Benefit Period	Effective January 1, 1989 Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective Jan. 1, 1989 Your Coverage Will Pay Per Calendar Year
--	--	--	--

PRESCRIPTION DRUGS

Inpatient prescription drugs only	In 1989 Medicare covers inpatient prescription drugs only
---	---

NOTE: Effective January 1, 1990,
per calendar year -- 80% of allowable
charges for home intravenous (IV)
therapy drugs and 50% of allowable
charges for immunosuppressive drugs
after calendar year deductible is
met (\$550 in 1990).

Effective January 1, 1991,
per calendar year -- Inpatient
prescription drugs: 50% of allowable
charges for all other outpatient
prescription drugs after a \$600
calendar year deductible is met.
(The deductible will change.)
Coverage will increase to 60% of
allowable charges in 1992 and to
80% of allowable charges from 1993
on.

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about premium adjustments that may be necessary due to changes in Medicare benefits or when premium information will be sent.)

This chart summarizing the changes in your Medicare benefits and in your Medicare supplement insurance provided by (company) , only briefly describes such benefits. For information on your Medicare benefits contact your Social Security office or the Health Care Financing Administration. For information on your Medicare supplement (policy) contact: (company name -- or name of agent) (address) (phone number).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-165, filed 11/1/88.]

WAC 284-55-170 Form of annual adjustment notice--Policy changes effective January 1, 1990.

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE -- 1990

Your health care benefits provided by the federal Medicare program will change beginning January 1, 1990. Additional change will occur on medical benefits in following years. The major changes are summarized below. These changes will affect hospital, medical and other services and supplies provided under Medicare. Because of these changes your Medicare supplement coverage provided by _____(company name)_____ will change, also. The following outline briefly describes the modifications to Medicare and in your Medicare supplement coverage. Please read carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format.)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

Medicare Now Pays Per Calendar Year	Effective January 1, 1990 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective Jan. 1, 1990 Your Coverage Will Pay Per Calendar Year
-------------------------------------	---	--	---

MEDICARE PART A: SERVICES AND SUPPLIES

Unlimited number of hospital days after [\$564] deductible

POSTHOSPITAL SKILLED NURSING CARE

There is no prior confinement requirement for this benefit

First 8 days - All but \$(____) a day

9th through 150th day -- 100% of costs

Beyond 150 days - Nothing

(Chart continued - For Use in 1990)

MEDICARE BENEFITSYOUR MEDICARE SUPPLEMENT
COVERAGE

Medicare Now	Effective January 1, 1990 Medicare Will	Your Coverage	Effective Jan. 1,
Pays Per	Pay Per Calendar	Now Pays	1990 Your Coverage
Calendar Year	Year	Per Calendar	Will Pay Per
		Year	Calendar Year

MEDICARE PART B: SERVICES AND SUPPLIES

80% of allowable charges
(after \$75.00 deductible)
until an annual Medicare
Catastrophic Limit is met.
100% of allowable charges
for the remainder of the
calendar year. The limit
in 1990 is \$(1370)* and will
be adjusted on an annual
basis.

PRESCRIPTION DRUGS

Inpatient prescription
drugs. 80% of allowable
charges for home intravenous
(IV) therapy drugs and 50%
of allowable charges for
immunosuppressive drugs
after calendar year
deductible is met
(\$550 in 1990).

* Expenses that count toward the Part B Medicare Catastrophic Limit include:
the Part B deductible and copayment charges and the Part B blood deductible
charges.

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about premium adjustments that may be necessary due to
changes in Medicare benefits or when premium information will be sent.)

This chart summarizing the changes in your Medicare benefits and in your
Medicare supplement insurance provided by ___(company)___, only briefly describes
such benefits. For information on your Medicare benefits contact your social
security office or the health care financing administration. For information
on your Medicare supplement (policy) contact: _____(company name -- or name
of agent) (address) (phone number).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2), 88-22-061 (Order R 88-9), § 284-55-170, filed 11/1/88.]

WAC 284-55-175 Form of annual adjustment notice--Policy changes effective January 1, 1991.

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE -- 1991

Your health care benefits provided by the federal Medicare program will change beginning January 1, 1991. Additional change will occur on medical benefits in following years. The major changes are summarized below. These changes will affect hospital, medical and other services and supplies provided under Medicare. Because of these changes your Medicare supplement coverage provided by _____(company name)_____ will change, also. The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format.)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

	Effective January 1, 1991	Your Coverage Now	Effective Jan. 1, 1991
Medicare Now Pays Per Calendar Year	Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Your Coverage Will Pay Per Calendar Year

MEDICARE PART A: SERVICES AND SUPPLIES

Unlimited number of hospital days after [\$_____] deductible

POSTHOSPITAL SKILLED NURSING CARE

There is no prior confinement requirement for this benefit

First 8 days - All but \$(____) a day

9th through 150th day -- 100% of costs

Beyond 150 days - Nothing

(Chart continued - For Use in 1991)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT
COVERAGE

Medicare Now	Effective Jan. 1, 1991 Medicare	Your Coverage Now Pays	Effective Jan. 1, 1991 Your Coverage
Pays Per	Will Pay Per	Per Calendar	Will Pay Per
Calendar Year	Calendar Year	Year	Calendar Year

MEDICARE PART B: SERVICES AND SUPPLIES

80% of allowable charges
(after \$75.00 deductible)
until an annual Medicare
Catastrophic Limit is met.
100% of allowable charges
for the remainder of the
calendar year. The limit
in 1991 is \$ _____ * and will
be adjusted on an annual
basis.

* Expenses that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

PRESCRIPTION DRUGS

Inpatient prescrip-
tion drugs. 50% of
allowable charges
for all other out-
patient prescription
drugs, until \$600
year deductible
is met (\$550 in
1990).

Inpatient prescription
drugs 60% of allowable
charges for all other
outpatient prescription
drugs, until \$652
calendar year deductible
is met. Coverage will
increase to 80% of
allowable charges from
1993 on, and deductible
will be adjusted on an
annual basis.

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about premium adjustments that may be necessary due to changes in Medicare benefits or when premium information will be sent.)

This chart summarizing the changes in your Medicare benefits and in your Medicare supplement insurance provided by ___(company)___, only briefly describes such benefits. For information on your Medicare benefits contact your Social Security office or the Health Care Financing Administration. For information on your Medicare supplement (policy) contact: _____(company name -- or name of agent) (address) (phone number).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-175, filed 11/1/88.]

WAC 284-55-180 Requirements for advertising. (1) At least thirty days prior to use in this state, every insurer who provides Medicare supplement insurance coverage to a resident of this state shall provide the commissioner with a copy of any advertisement, as defined at WAC 284-50-030, intended for use in this state, whether through written, radio, or television medium. In the case of radio or television advertising, an audio cassette or VHS video cassette shall be supplied on request of the commissioner.

(2) Advertisements shall comply with the Washington disability advertising regulation, RCW 48.30.040 through 48.30.090, and all other applicable state laws.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-180, filed 11/1/88.]

WAC 284-55-185 Compliance with Omnibus Budget Reconciliation Act of 1987. Every insurer to whom it applies shall certify to the commissioner on the Medicare supplement experience exhibit of its annual statement that it has complied with Section 4081 of the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, (1987).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-185, filed 11/1/88.]

WAC 284-55-190 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate a Medicare supplement insurance policy under other sections of Title 48 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-190, filed 11/1/88.]

Chapter 284-74 WAC

APPROVED INSURANCE TABLES

WAC

284-74-010	1983 Annuity tables.
284-74-100	Smoker/nonsmoker mortality tables.
284-74-200	Gender blended mortality tables for individual life insurance policies.

WAC 284-74-010 1983 Annuity tables. The purpose of this section is to recognize new mortality tables, the 1983 table "a" and the 1983 GAM table, for use in determining the minimum standard of valuation for annuity and pure endowment contracts.

(1) The 1983 table "a" mortality table, which was developed by the society of actuaries committee to recommend a new mortality basis for individual annuity valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners (NAIC), and which is set forth in NAIC Proceedings, 1982 Vol. II, p. 454, is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued or delivered in this state on or after July 10, 1982.

(2) The 1983 table "a" referred to in subsection (1) of this section is to be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued or delivered in this state on or after January 1, 1988.

(3) The 1983 GAM mortality table, which was developed by the society of actuaries committee on annuities and adopted as a recognized mortality table for annuities in December 1983 by the NAIC, and which is set forth in NAIC Proceedings, 1984 Vol. I, pp. 414-415, and the 1983 table "a" mortality table referred to in subsection (1) of this section, are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, either table may be used for purposes of valuation for any annuity or pure endowment purchased on or after July 10, 1982, under a group annuity or pure endowment contract.

(4) The 1983 GAM table referred to in subsection (3) of this section is to be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1988 under a group annuity or pure endowment contract.

[Statutory Authority: RCW 48.02.060. 87-05-046 (Order R 87-3), § 284-74-010, filed 2/18/87.]

WAC 284-74-100 Smoker/nonsmoker mortality tables. The purpose of this section is to permit the use of mortality tables approved by the National Association of Insurance Commissioners (NAIC) that reflect differences in mortality between smokers and nonsmokers in determining minimum reserve liabilities, minimum cash surrender values and amounts of paid-up nonforfeiture benefits for plans of insurance with separate premium rates for smokers and nonsmokers.

(1) As used in this section, the following definitions apply:

(a) "1980 CSO table, with or without ten-year select mortality factors," means that mortality table consisting of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC amendments to the model standard valuation law and standard nonforfeiture law for life insurance and referred to in those models as the commissioners 1980 standard ordinary mortality table, with or without ten-year select mortality factors and set forth in *Transactions, Society of Actuaries*, Vol. XXXIII (1981), pp. 617 and 618, and referred to as commissioners 1980 standard ordinary mortality table (1980 CSO). The same select factors will be used for both smokers and nonsmokers tables. These select factors are set forth in *Transactions, Society of Actuaries*, Vol. XXXIII (1981), p. 669, and referred to therein as selection factors for alternate method of determining life insurance reserves and deficiency reserve requirements (1980 CSO with ten-year select mortality factors).

(b) "1980 CET table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation

of standard individual ordinary life insurance, incorporated in the 1980 NAIC amendments to the standard model nonforfeiture law for life insurance and referred to in those models as the commissioners 1980 extended term insurance table, and set forth in *Transactions, Society of Actuaries*, Vol. XXXIII (1981), pp. 617 and 619, and referred to as commissioners 1980 extended term insurance mortality table (1980 CET).

(c) "1958 CSO table" means that mortality table developed by the society of actuaries special committee on new mortality tables, incorporated in the NAIC model standard nonforfeiture law for life insurance and referred to in that model as the commissioners 1958 standard ordinary mortality table, and set forth in *Proceedings of the National Association of Insurance Commissioners*, 1959, Vol. I, p. 195 (also see 1960, Vol. I, p. 211, and 1978, Vol. I, p. 537) and referred to as commissioners 1958 standard ordinary mortality table (1958 CSO).

(d) "1958 CET table" means that mortality table developed by the society of actuaries special committee on new mortality tables, incorporated in the NAIC model standard nonforfeiture law for life insurance and referred to in that model as the commissioners 1958 extended term insurance table, and set forth in *Proceedings of the National Association of Insurance Commissioners*, 1959, Vol. I, p. 196, and referred to as commissioners 1958 extended term insurance mortality table (1958 CET).

(e) The phrase "smoker and nonsmoker mortality tables" refers to the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the tables defined in (a) through (d) of this subsection which were developed by the society of actuaries task force on smoker/nonsmoker mortality and the California insurance department staff and recommended by the NAIC technical staff actuarial group, and are published in *Proceedings, National Association of Insurance Commissioners*, 1984, Vol. I, pp. 402-413.

(f) The phrase "composite mortality tables" refers to the mortality tables defined in (a) through (d) of this subsection as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

(2) For any policy of insurance delivered or issued for delivery in this state after the effective date of this section and before January 1, 1989, at the option of the company and subject to the conditions stated in subsection (4) of this section:

(a) The 1958 CSO smoker and nonsmoker mortality tables may be substituted for the 1958 CSO table; and

(b) The 1958 CET smoker and nonsmoker mortality tables may be substituted for the 1958 CET table for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

Provided that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits determined using the 1958 CSO or 1958 CET smoker and nonsmoker mortality tables,

such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

Provided further that the substitution of the 1958 CSO or 1958 CET smoker and nonsmoker mortality tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the effective date of this section and before a date not later than January 1, 1989.

(3) For any policy of insurance delivered or issued for delivery in this state after the effective date of this regulation, at the option of the company and subject to the conditions stated in subsection (4) of this section:

(a) The 1980 CSO smoker and nonsmoker mortality tables, with or without ten-year select mortality factors, may be substituted for the 1980 CSO table, with or without ten-year select mortality factors; and

(b) The 1980 CET smoker and nonsmoker mortality tables may be substituted for the 1980 CET table for use in determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(4) Conditions. For each plan of insurance with separate rates for smokers and nonsmokers an insurer may:

(a) Use composite mortality tables to determine minimum reserve liabilities, minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(b) Use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by RCW 48.74.070 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(c) Use smoker and nonsmoker mortality tables to determine minimum reserve liabilities, minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(5) For purposes of determining nonforfeiture values and reserves, this section applies to all individual life insurance policies as defined in RCW 48.11.020 which are issued or delivered in this state after December 31, 1986. For purposes of RCW 48.74.070 (Minimum reserve if gross premium less than valuation net premium), this section applies to all individual life insurance policies as defined in RCW 48.11.020 which are issued or delivered in this state after December 31, 1985.

[Statutory Authority: RCW 48.02.060, 87-05-046 (Order R 87-3), § 284-74-100, filed 2/18/87.]

WAC 284-74-200 Gender blended mortality tables for individual life insurance policies. The purpose of this section is to permit individual, franchise and group permanent (cash value) life insurance policies and pension plans funded in whole or in part by life insurance to provide the same cash values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is implied by this section.

(1) As used in this section, the following definitions apply:

(a) "1980 CSO table, with or without ten-year select mortality factors," means that mortality table, consisting

of separate rates of mortality for male and female lives, developed by the society of actuaries committee to recommend new mortality tables for valuation of standard ordinary life insurance incorporated in the 1980 National Association of Insurance Commissioners (NAIC) amendments to the model standard valuation law and standard nonforfeiture law for life insurance and referred to in those models as the Commissioner's 1980 Standard Ordinary Mortality Table, with or without ten-year select mortality factors and set forth in Transactions, Society of Actuaries, Vol. XXXIII (1981), pp. 617 and 618, and referred to as the Commissioner's 1980 Standard Ordinary Mortality Table (1980 CSO).

(b) "1980 CSO table (M), with or without ten-year select mortality factors," means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO table, with or without ten-year select mortality factors.

(c) "1980 CSO table (F), with or without ten-year select mortality factors," means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO table, with or without ten-year select mortality factors.

(d) The "ten-year select mortality factors" referred to in (a), (b), and (c) of this subsection are those set forth in Transactions, Society of Actuaries, Vol. XXXIII (1981), p. 669, and referred to therein as selection factors for alternate method of determining life insurance reserves and deficiency reserve requirements (1980 CSO with ten-year select mortality factors).

(e) "1980 CET table" means that mortality table consisting of separate rates of mortality for male and female lives developed by the society of actuaries committee to recommend new mortality tables for valuation of standard individual ordinary life insurance, incorporated in the 1980 NAIC amendments to the standard model nonforfeiture law for life insurance and referred to in those models as the Commissioner's 1980 Extended Term Insurance Table, and set forth in Transactions, Society of Actuaries, Vol. XXXIII (1981), pp. 617 and 619, and referred to therein as the Commissioner's 1980 Extended Term Insurance Mortality Table (1980 CET).

(f) "1980 CET table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET table.

(g) "1980 CET table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET table.

(2) For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this state after the operative date of chapter 48.76 RCW for that policy form, for use in determining minimum cash surrender values and minimum amounts and minimum periods of paid-up nonforfeiture benefits:

(a) A mortality table which is a blend of the 1980 CSO table (M) and the 1980 CSO table (F) with or without ten-year select mortality factors may at the option of the company be substituted for the 1980 CSO table, with or without ten-year select mortality factors.

(b) A mortality table which is of the same blend as used in (a) of this subsection but applied to form a blend

of the 1980 CET table (M) and the 1980 CET table (F) may at the option of the company be substituted for the 1980 CET table.

(c) The following tables, which are set forth in NAIC Proceedings, Vol. I, pp. 396-400, will be considered as the basis for acceptable tables:

(i) 100% male - 0% female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" tables.

(ii) 80% male - 20% female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" tables.

(iii) 60% male - 40% female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" tables.

(iv) 50% male - 50% female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" tables.

(v) 40% male - 60% female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" tables.

(vi) 20% male - 80% female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" tables.

(vii) 0% male - 100% female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" tables.

(3) Tables 1980 CSO-A, 1980 CET-A, 1980 CSO-G and 1980 CET-G are not to be used with respect to policies issued on or after the effective date of this regulation, except where the proportion of persons insured is anticipated to be ninety percent or more of one sex or the other or except for certain policies converted from group insurance. Such group conversions issued on or after the effective date of this regulation must use mortality tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the Norris decision or other federal law. This consideration has not been clearly defined by court or legislative action in all jurisdictions as of the date of promulgation of these sections.

(4) Notwithstanding any other provision of this rule, an insurer shall not use these blended tables unless the Norris decision or other federal law is known to apply to the policies involved, or unless there exists a bona fide concern on the part of the insurer that the Norris decision or other federal law might reasonably be construed to apply by a court having jurisdiction.

(5) It shall not be a violation of RCW 48.30.300 for an insurer to issue the same kind of policy of life insurance on both a sex distinct and sex neutral basis.

(6) The effective date of this rule is February 29, 1987, and is intended to comply with the Norris decision and other federal law. It is recognized that the insurance commissioner has approved Norris-type tables prior to this effective date on an individual basis. Tables so approved are hereby deemed to be in compliance with this regulation.

[Statutory Authority: RCW 48.02.060, 88-04-054 (Order R 88-1), § 284-74-200, filed 1/29/88, effective 2/29/88.]

Chapter 284-91 WAC

HEALTH INSURANCE ACCESS REGULATION

WAC

284-91-010

284-91-020

284-91-025

Board of directors.

Organizational meeting, duties of board of directors.

Plan of operation approved.

284-91-027	Plan of operation.
284-91-030	Duties of administrator.
284-91-040	Forms to be used by administrator.

WAC 284-91-010 Board of directors. Pursuant to section 4(2), chapter 431, Laws of 1987, a board of directors for the Washington state health insurance pool is hereby established. Nine directors shall comprise the board, and shall be selected by position as follows:

(1) Individual persons shall be appointed by the commissioner to positions one, two, and three. Position one will represent the general public. Position two will represent health care providers. Position three will represent health insurance agents.

(2) At the organizational meeting six directors shall be elected by the "members" of the Washington state health insurance pool in attendance at such meeting. The statutory definition of "member" is set forth in section 3(12), chapter 431, Laws of 1987. Nomination for the members' positions shall be in accordance with the following procedures:

(a) Members who are health care service contractors, registered pursuant to chapter 48.44 RCW, shall nominate one member for position four. In the determination of the nominee for position four, each health care service contractor is entitled to one vote. The contractors will then nominate one member for position five. In the determination of the nominee for position five, each health care service contractor's vote shall be weighted in proportion to its share of the earned premiums received by all member contractors during the preceding calendar year. A health care service contractor is not eligible for position four or position five if it is controlled by a health maintenance organization or a commercial insurer.

(b) Members who are health maintenance organizations with certificates of authority pursuant to chapter 48.46 RCW shall nominate one member for position six. In the determination of the nominee for position six, each health maintenance organization is entitled to one vote. The health maintenance organizations will then nominate one member for position seven. In the determination of the nominee for position seven, each health maintenance organization's vote shall be weighted in proportion to its share of the total earned premium received by all member organizations during the preceding calendar year. A health maintenance organization is not eligible for position six or position seven if it is controlled by a health care service contractor or a commercial insurer.

(c) Members who are commercial insurers providing disability insurance pursuant to certificates of authority issued by the commissioner, shall nominate one member for position eight. In the determination of the nominee for position eight, each commercial insurer is entitled to one vote. The commercial insurers will then nominate a member for position nine. In the determination of the nominee for position nine, each commercial insurer's vote shall be weighted in proportion to its share of the total earned premiums for disability insurance received by all commercial insurers during the preceding calendar year. A commercial insurer is not eligible for position

eight or position nine if it is controlled by a health care service contractor or a health maintenance organization.

(d) If, in the nomination process, more than two members are proposed and the resulting vote fails to produce a majority for any candidate, succeeding ballots will be conducted, each dropping the candidate with the lowest vote on the previous ballot until one member receives a majority vote for nomination.

(e) If, in the nominating process, there is a tie vote, the prevailing member will be determined by the flip of a coin, with the nominee whose name comes first in alphabetical order making the call of heads or tails.

(f) For purposes of proportional voting in the nominating process, "earned premium" is that amount reported from the state of Washington in the most recent annual statement filed with the commissioner.

(3) The members nominated pursuant to subsection (2) of this section must be confirmed by a majority of the members present and voting at any election. If the confirming vote results in the rejection of any nominee proposed in accordance with subsection (2) of this section, the appropriate members will caucus and nominate a new candidate. Such nominee must be confirmed by a majority vote of those members present and voting.

(4) The following general rules apply to the nomination and election process set forth in subsections (2) and (3) of this section.

(a) Only one board position may be held by a member, its parent member or its subsidiary members.

(b) A member may serve as both the administrator and a director. However, a director which submits a bid to become the administrator is disqualified from participating in the board's considerations and decision in choosing the administrator. While a director is also serving as the administrator, it is disqualified from participating in the board's considerations and decisions concerning:

- (i) The compensation to be paid to the administrator;
- (ii) Its removal, renewal, or replacement as administrator; and
- (iii) Any matter in dispute between the board and the administrator.

(c) A member is eligible for election to the board of directors if, at time of election, it has at least one thousand persons insured under either individual or group contracts or both and has provided health expense benefits continuously for two or more years.

(d) Except as provided in subsections (2)(a), (b); and (c) of this section, each member shall have one vote which may be cast in person or by proxy granted in writing.

(e) Directors shall serve three-year terms or until a successor has been appointed or elected except as follows. The original directors in positions one, two, and three will first serve one-year terms. The original directors in positions four, six, and eight will first serve two-year terms. All other terms will be for three years or until a successor is appointed or elected.

(f) After the initial terms, elections for positions four through nine will be conducted in accordance with the procedures set forth in subsections (2) and (3) of this

section at a time and place designated by the plan of operation.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 88-11-010 (Order R 88-5), § 284-91-010, filed 5/10/88; 87-18-025 (Order R 87-9), § 284-91-010, filed 8/27/87.]

WAC 284-91-020 Organizational meeting, duties of board of directors. (1) The organizational meeting at which nominations and elections are conducted shall be called by the commissioner, pursuant to notice given by mail to all members, which notice shall specify the time, place, and purpose of such meeting. The organizational meeting will be conducted by the commissioner or his designee.

(2) The board of directors shall meet at least once each calendar quarter with five directors constituting a quorum. The board shall:

(a) Select a presiding officer;

(b) Select an administrator which shall be either a member or an experienced third party administrator with an office in this state;

(c) Retain such legal, actuarial, accounting, or other professional services as the directors deem necessary to operate the high risk health pool in a sound and competent manner;

(d) Initiate such interim and regular assessments as may be reasonable and necessary for the operation of the high risk health pool in a sound and competent manner;

(e) Initiate efforts to develop a plan of operation as required by section 4(4), chapter 431, Laws of 1987; and

(f) Take such other action as the directors consider necessary and appropriate to properly initiate the activities of the high risk health pool pursuant to chapter 431, Laws of 1987.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 88-11-010 (Order R 88-5), § 284-91-020, filed 5/10/88; 87-18-025 (Order R 87-9), § 284-91-020, filed 8/27/87.]

WAC 284-91-025 Plan of operation approved. Pursuant to RCW 48.41.040(4) and after public hearing, the commissioner has determined that the Plan of Operation, as set forth in WAC 281-91-027, provides a sound basis for the fair, reasonable and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. It is hereby approved.

[Statutory Authority: RCW 48.02.060, 88-08-010 (Order R 88-4), § 284-91-025, filed 3/25/88.]

WAC 284-91-027 Plan of operation.

[Statutory Authority: RCW 48.02.060, 88-08-010 (Order R 88-4), § 284-91-027, filed 3/25/88.]

Reviser's note: The text of the adopted plan of operation filed by the Office of the Insurance Commissioner has been omitted from publication in the Washington Administrative Code. The code reviser, under the authority of RCW 34.04.050(3), has deemed it unduly cumbersome to publish.

WAC 284-91-030 Duties of administrator. The duties of the administrator shall be specified by the board of directors and include but not be limited to:

(1) Keeping minutes of the board meetings and maintaining a permanent record of the activities of the pool.

(2) Performing the day-to-day administration of the pool including collection of premiums and assessments, processing of claims, and the maintenance of such statistical data as may be necessary for the sound and orderly operation of the pool.

(3) Beginning with the first month for which premium is paid by participating insureds, submit to the board and the commissioner a report indicating the number of insureds by classification, the dollar amount of premiums received and claims paid in each classification and such other information as the directors or the commissioner deem necessary to be informed as to the current claims experience of the pool. A report shall be prepared for each month with year-to-date totals and mailed not later than the 15th day of the following month.

(4) Within sixty days after the end of the first twelve months for which premiums have been paid, and annually thereafter, the administrator will submit to the commissioner and the directors the experience data required by WAC 284-91-040 consistent with the definitions set forth in chapter 284-60 WAC, and such other narrative and statistical data as may be required for the commissioner or the board to keep them fully informed as to the operations and experience of the high risk health pool for each twelve-month period. Forms providing equivalent information in a clear and understandable manner may be substituted for the formats set forth in WAC 284-91-040.

(5) Such other duties and responsibilities as required by chapter 431, Laws of 1987, or as may be ordered by the board of directors.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-025 (Order R 87-9), § 284-91-030, filed 8/27/87.]

WAC 284-91-040 Forms to be used by administrator.

(1) PLAN A - PRIMARY INSURED
HIGH RISK HEALTH POOL - \$500 DEDUCTIBLE PLAN
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
HOSPITAL							
SURGICAL							
MEDICAL							
DIAGNOSTIC							
MENTAL, ETC.							
PRESCRIPTIONS							
HOME HEALTH							
X-RAY THERAPY							
ANESTHESIA							
DURABLE EQUIP.							
THERAPY							
AMBULANCE							
HOSPICE							
ALL OTHERS	_____	_____	_____	_____	_____	_____	_____
COMBINED TOTALS							

(2) PLAN A - DEPENDENT INSURED
HIGH RISK HEALTH POOL - \$500 DEDUCTIBLE PLAN
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
HOSPITAL							
SURGICAL							
MEDICAL							
DIAGNOSTIC							
MENTAL, ETC.							
PRESCRIPTIONS							
HOME HEALTH							
X-RAY THERAPY							
ANESTHESIA							
DURABLE EQUIP.							
THERAPY							
AMBULANCE							
HOSPICE							
ALL OTHERS	_____	_____	_____	_____	_____	_____	_____
COMBINED TOTALS							

Health Insurance Access Regulation

284-91-040

(3) PLAN B - PRIMARY INSUREDS
HIGH RISK HEALTH POOL - \$1,000 DEDUCTIBLE PLAN
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
HOSPITAL							
SURGICAL							
MEDICAL							
DIAGNOSTIC							
MENTAL, ETC.							
PRESCRIPTIONS							
HOME HEALTH							
X-RAY THERAPY							
ANESTHESIA							
DURABLE EQUIP.							
THERAPY							
AMBULANCE							
HOSPICE							
ALL OTHERS	_____	_____	_____	_____	_____	_____	_____
COMBINED TOTALS							

(4) PLAN B - DEPENDENT COVERAGE
HIGH RISK HEALTH POOL - \$1,000 DEDUCTIBLE PLAN
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
HOSPITAL							
SURGICAL							
MEDICAL							
DIAGNOSTIC							
MENTAL, ETC.							
PRESCRIPTIONS							
HOME HEALTH							
X-RAY THERAPY							
ANESTHESIA							
DURABLE EQUIP.							
THERAPY							
AMBULANCE							
HOSPICE							
ALL OTHERS	_____	_____	_____	_____	_____	_____	_____
COMBINED TOTALS							

(5) PLAN C HIGH RISK HEALTH POOL - MEDICARE SUPPLEMENTS							
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____							
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
SUPPLEMENT TO PART A MEDICARE							
SUPPLEMENT TO PART B MEDICARE							

COMBINED TOTALS							
(6) ALL PLANS COMBINED HIGH RISK HEALTH POOL							
EXPERIENCE REPORT FOR THE PERIOD FROM _____ THROUGH _____							
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
COVERAGE	<u>Earned Premium</u>	<u>Incurred Claims</u>	<u>Expense Charges</u>	<u>Surplus (Deficit)</u>	<u>Incurred Loss Ratio (2) ÷ (1)</u>	<u>Expense Ratio (3) ÷ (1)</u>	<u>Combined Ratio (5) + (6)</u>
PLAN A PRIMARY INSURED							
PLAN A DEPENDENT COVERAGE							
PLAN B PRIMARY INSURED							
PLAN B DEPENDENT COVERAGE							
PLAN C MEDICARE SUPPLEMENT							

COMBINED TOTALS							

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-025 (Order R 87-9), § 284-91-040, filed 8/27/87.]

Title 286 WAC
INTERAGENCY COMMITTEE FOR
OUTDOOR RECREATION

Chapter 286-16 Eligibility for state outdoor recreation grant-in-aid assistance.

Chapter 286-16 WAC
ELIGIBILITY FOR STATE OUTDOOR
RECREATION GRANT-IN-AID ASSISTANCE

WAC 286-16-035 Applications--Deadlines.

WAC 286-16-035 Applications--Deadlines. (1) All project applications from local agencies must be submitted at least four months prior to a scheduled funding meeting to be considered at that meeting. Project applications from local agencies that are not completed in the manner required by these rules and the participation manuals will not be considered by the interagency committee unless all of the required material is on file with the interagency committee at least 30 days preceding a funding meeting at which the projects are to be considered for funding.

(2) These deadlines must be complied with unless an agency requests and is granted a waiver by the director.

[Statutory Authority: Chapter 43.99 RCW. 87-08-032 (Order 87-1), § 286-16-035, filed 3/27/87. Statutory Authority: RCW 43.99.010, 43.99.110, 43.99.080, 43.99.120, 43.99.060, 42.17.370, 46.09.020, 46.09.170 and 46.09.240. 83-01-030 (Order IAC 82-1), § 286-16-035,