

Title 284 WAC

INSURANCE COMMISSIONER

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DISPOSITION OF CHAPTERS FORMERLY CODIFIED IN THIS TITLE

Chapter 284-08 PRACTICE AND PROCEDURE

Reviser's note: Practice and procedure rules, WAC 284-08-010 through 284-08-590, were filed with the code reviser's office 3/22/60. They were repealed by insurance commissioner Order No. R 68-3, the pertinent portion of which reads as follows:

WAC 284-08-001 repeal of rules of PRACTICE and PROCEDURE (chapter 284-08 WAC). "I, LEE I. KUECKELHAN, insurance commissioner of the state of Washington, . . . do hereby repeal the above-entitled rules effective July 11, 1968, on the grounds that such rules and regulations are substantially contained in Title 1, Washington Administrative Code, which are intended to be the uniform rules of practice and procedure for state administrative agencies. . . ." [Order No. R 68-3 (part), filed 6/12/68.]

Chapter 284-40 REGISTRATION OF FUNERAL ESTABLISHMENTS

- 284-40-010 Purpose. [Order R 77-6, § 284-40-010, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-020 Effective date and scope. [Order R 77-6, § 284-40-020, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-030 Definitions. [Order R 77-6, § 284-40-030, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-040 Registration. [Order R 77-6, § 284-40-040, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-050 Prearrangement funeral service contract form requirements. [Order R 77-6, § 284-40-050, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-060 Requirements as to trust funds. [Order R 77-6, § 284-40-060, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.
- 284-40-070 Annual statement requirements. [Order R 77-6, § 284-40-070, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.

284-40-080 Renewal of certificate of registration. [Order R 77-6, § 284-40-080, filed 11/3/77, effective 12/5/77.] Repealed by 83-14-001 (Order R 83-2), filed 6/23/83. Statutory Authority: RCW 48.02.060.

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.
284-02-090	Public access to information and records.
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 four major divisions: Administrative, company supervision, rates and forms regulation, 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). The commissioner may appoint a chief hearing officer who will have primary responsibility for the conduct of hearings, the procedural matters preliminary thereto, and the preservation of hearing records. The position of chief hearing officer does not report to any of the three major divisions of the commissioner's office.

(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.

(a) Admissions of companies. Admission of insurance companies and fraternal benefit societies 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).

(3) Rates and forms regulation division.

(a) This division reviews policy forms, health care service contracts, and health maintenance organization agreements, and any applications, policy riders or endorsements appertaining thereto (RCW 48.18.100, 48.44.040, 48.44.070, 48.46.060, or 48.66.035). Such forms are disapproved if, upon review, they are found to violate the provisions of RCW 48.18.110, 48.44.020, 48.44.070, 48.46.060, or 48.66.035.

(b) The rates and forms regulation division reviews the rates used by insurers, including health care service contractors and health maintenance organizations (RCW 48.19.010(2), 48.19.040, 48.29.140, 48.44.040, 48.46.060, 48.66.035, or 48.84.030). Rates filed in accordance with RCW 48.19.040 and 48.66.035 are disapproved if they are found to violate RCW 48.19.020 or 48.66.035. Rates submitted pursuant to RCW 48.19.010(2), 48.44.040, 48.46.060, or 48.84.030 are filed in accordance with the appropriate section; however, approval is withdrawn from the form of policy, contract, or agreement for which the rates are being filed if, upon review, it is determined that the benefits are unreasonable in relation to the premiums charged (RCW 48.18.110(2), 48.44.020, 48.46.060, or 48.84.030). Rates submitted pursuant to RCW 48.29.140 or 48.34.100 are filed in accordance with chapters 48.29 and 48.34 RCW.

(c) The rates and forms regulation division is responsible for supervising the admission of health care service contractors and health maintenance organizations, as well as for analyzing their financial solvency and reviewing their overall operation (chapters 48.44 and 48.46 RCW).

(4) 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.

(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) 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 proceed-

ings leading to fines, license revocations or suspensions, as appropriate.

(5) 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. In order to assure the objectivity of advice given by SHIBA volunteers, the commissioner has determined that no one connected to the SHIBA program may be an active agent of an insurer selling disability insurance policies or contracts in this state.

(6) 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.

(7) 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. 92-23-009 (Order R 92-18), § 284-02-020, filed 11/6/92, effective 12/7/92. Statutory Authority: RCW 48.02.060 (3)(a). 91-17-013 (Order R 91-5), § 284-02-020, filed 8/13/91, effective 9/13/91. Statutory Authority: RCW 48.02.060 and 48.02.160(3). 90-17-058 (Order R 90-8), § 284-02-020, filed 8/14/90, effective 9/14/90. 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. (1) 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.

(2) Where service of process against a foreign or alien insurer is made through service upon the commissioner pursuant to RCW 48.05.210 or 48.05.215, such service must be made by personal service at, or by registered mail sent to, the Olympia, Washington office of the insurance commissioner, and otherwise comply with the requirements of the applicable statute. Service upon a branch office is not

permissible and will not be accepted. Pursuant to RCW 1.12.060, whenever the use of "registered" mail is called for, "certified" mail with return receipt requested, may be used.

[Statutory Authority: RCW 48.02.060 (3)(a). 91-17-013 (Order R 91-5), § 284-02-030, filed 8/13/91, effective 9/13/91; 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 (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 to the commissioner at his Olympia office, 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 (chapter 34.05 RCW). 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 (chapter 34.05 RCW). 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 ag-

grieved 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)).

(3) Rule-making hearings. Rule-making hearings of the insurance commissioner are conducted pursuant to the Administrative Procedure Act (chapter 34.05 RCW), 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), 91-17-013 (Order R 91-5), § 284-02-070, filed 8/13/91, effective 9/13/91; 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 284-02-090 Public access to information and records. Notwithstanding anything contained in this chapter or this title to the contrary, access by the public to information and records of the insurance commissioner shall be governed by chapter 284-03 WAC.

[Order R-75-2, § 284-02-090, filed 5/19/75.]

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 284-03 WAC

PUBLIC ACCESS TO INFORMATION AND RECORDS

WAC

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284-03-080	Requests for public records.
284-03-090	Copying fees.
284-03-100	Exemptions.
284-03-110	Review of denials of public records request.
284-03-120	Protection of public records.
284-03-130	Consumer complaints and inquiries.
284-03-140	Adoption of forms.
284-03-990	Form 276-1—Request for inspection of records.
284-03-99001	Form 276-2—Request for photocopy of record(s).

WAC 284-03-010 Purpose. The purpose of this chapter is to provide rules implementing RCW 42.17.250—42.17.320 (§§ 25 through 32, chapter 1, Laws of 1973).

[Order R-75-1, § 284-03-010, filed 5/19/75.]

WAC 284-03-020 Definitions. (1) The definitions set forth in RCW 42.17.020 shall apply to this chapter.

(2) "Office" is the office of the insurance commissioner of the state of Washington, which includes by operation of law the office of the state fire marshal.

[Order R-75-1, § 284-03-020, filed 5/19/75.]

WAC 284-03-030 Functions—Organization—Administration. (1) For purposes of this chapter, the functions, organization and administration of the office relating to insurance matters shall be as set forth in chapter 284-02 WAC.

(2) For purposes of this chapter, the functions, organization and administration of this office relating to the state fire marshal shall be as set forth in chapter 212-02 WAC.

[Order R-75-1, § 284-03-030 (codified as WAC 284-03-030), filed 5/19/75.]

WAC 284-03-040 Public records available. Public records are available for public inspection and copying pursuant to these rules except as otherwise provided by RCW 42.17.310 and these rules.

[Order R-75-1, § 284-03-040, filed 5/19/75.]

WAC 284-03-050 Public records officer. The public records officer for the office shall be the administrative officer, as designated by the state insurance commissioner, for all records maintained by such office whether located at the central office thereof at Olympia, Washington, or at such other offices throughout the state maintained by the state

insurance commissioner. The public records officer shall be located at such central office. The public records officer shall be responsible for implementation of this chapter regarding release of public records, coordinating the staff of the office in this regard, generally insuring compliance by the staff with the public records disclosure requirements of RCW 42.17.250—42.17.320, and maintaining the records index of such office as required.

[Order R-75-1, § 284-03-050, filed 5/19/75.]

WAC 284-03-060 Records index. The office has available to all persons a current index which provides identifying information as to public records received, issued, adopted or promulgated since its inception. The current index adopted by the office shall be available to all persons under the same rules and on the same conditions as are applied to public records available for inspection.

The indexes shall be kept current and maintained by the commissioner's designee, located in the Olympia office, and shall be updated no less frequently than annually. All indexes maintained by the commissioner shall be indexed by appropriate names, by calendar year, by topic, or a combination of these, as appropriate.

[Statutory Authority: RCW 48.02.060, 48.02.160, 42.17.260 and 34.05.220, 90-18-037 (Order R 90-9), § 284-03-060, filed 8/28/90, effective 9/28/90; Order R-75-1, § 284-03-060, filed 5/19/75.]

WAC 284-03-070 Office hours. Public records shall be available for inspection and copying during the customary office hours of the office. For purposes of this chapter, the customary office hours shall be from 9:00 a.m. to noon and from 1:00 p.m. to 4:00 p.m., Monday through Friday, excluding legal holidays.

[Order R-75-1, § 284-03-070, filed 5/19/75.]

WAC 284-03-080 Requests for public records. In accordance with requirements of RCW 42.17.250—42.17.320 that agencies prevent unreasonable invasions of privacy, protect public records from damage or disorganization, and prevent excessive interference with essential functions of the agency, public records may be inspected or copied or copies of such records may be obtained, by members of the public, upon compliance with the following procedures:

(1) A request shall be made in writing upon a form prescribed by the office which shall be available at its public records officer; or to any member of the office staff, if the public records officer is not available, at the administrative office during customary office hours. The request shall include the following information:

- (a) The name of the person requesting the record;
- (b) The time of day and calendar date on which the request was made;
- (c) The nature of the request;
- (d) If the matter requested is referenced within the current index maintained by the records officer, a reference to the requested record as it is described in such current index;
- (e) If the requested matter is not identifiable by reference to the current index, an appropriate description of the record requested.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public records officer or staff member to whom the request is made to assist the member of the public in appropriately identifying the public record requested.

[Order R-75-1, § 284-03-080, filed 5/19/75.]

WAC 284-03-090 Copying fees. No fee shall be charged for the inspection of public records. The office will charge a per-page fee for providing copies of public records. If copies of photographs are requested, a fee will be charged for the duplication of such photographs. Copying fees will be set at amounts equal to the actual costs to the office incident to such copying, including costs of materials, machinery, and personnel. The fees charged will be reviewed periodically to assure their accuracy, and shall be modified accordingly.

[Statutory Authority: RCW 42.17.250 and 42.17.300, 79-08-024 (Order R 79-4), § 284-03-090, filed 7/12/79; Order R-75-1, § 284-03-090, filed 5/19/75.]

WAC 284-03-100 Exemptions. (1) The office reserves the right to determine that a public record requested in accordance with the procedures outlined in WAC 284-03-080 is exempt under the provisions of RCW 42.17.260 and/or such other laws as may be deemed applicable.

(2) In addition, pursuant to RCW 42.17.260 the office reserves the right to delete identifying details when it makes available or publishes any public record in any cases when there is reason to believe that disclosure of such details would be an invasion of personal privacy or as otherwise provided in WAC 284-03-040. The public records officer will fully justify such deletion in writing.

(3) All denials of requests for public records must be accompanied by a written statement specifying the reason for the denial, including a statement of the specific exemption authorizing the withholding of the record and a brief explanation of how the exemption applies to the record withheld.

[Order R-75-1, § 284-03-100, filed 5/19/75.]

WAC 284-03-110 Review of denials of public records request. (1) Any person who objects to the denial of a request for a public record may petition for prompt review of such decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public records officer or other staff member which constituted, or accompanied the denial.

(2) Immediately after receiving a written request for review of a decision denying a public record, the public records officer or other staff member denying the request shall refer it to the insurance commissioner or a designated deputy insurance commissioner. The commissioner or his designee shall immediately consider the matter and either affirm or reverse such denial or call a special meeting of the members of the office staff necessary to properly consider the matter and/or request a legal review thereof by the assistant attorney general representing the office. In any case, the request shall be returned with a final decision, within five business days following the original denial.

(3) Administrative remedies shall not be considered exhausted until the office has returned the petition with a

decision or until the close of the fifth business day following denial of inspection, whichever occurs first.

[Order R-75-1, § 284-03-110, filed 5/19/75.]

WAC 284-03-120 Protection of public records. The public records officer shall to the extent practicable insure that records requested are not removed from the premises nor portions thereof removed by members of the public.

[Order R-75-1, § 284-03-120, filed 5/19/75.]

WAC 284-03-130 Consumer complaints and inquiries. Unless a consumer complainant or inquirer specifically provides to the contrary, the public records officer or other members of the office staff are authorized when deemed appropriate to forward a copy of the letter or other writings pertinent to the complaint or inquiry to the firm or person which is the subject of the complaint or to any firm or person who may provide assistance relative to the complaint or inquiry.

[Order R-75-1, § 284-03-130, filed 5/19/75.]

WAC 284-03-140 Adoption of forms. The office hereby adopts for use by all persons requesting inspection and/or copies of records the forms attached hereto entitled "Request for inspection of records" and "Request for photocopy of records."

[Order R-75-1, § 284-06-140 (codified as WAC 284-03-140), filed 5/19/75.]

WAC 284-03-990 Form 276-1—Request for inspection of records.

.....
Request Number
.....
Date requested
.....
Date provided
.....
(For office use only)

OFFICE OF INSURANCE COMMISSIONER
Request for Inspection of Records

The information requested in Blocks 1 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

1. Name	4. Phone number
2. Address	5. Representing (if applicable)
3. Zip code	6. If urgent - date needed

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(Signed)
Date

Insurance
Commissioner
Form 276 - 1
(Page 1 of 2 - Exhibit 1)

[Order R-75-1, Form 276-1 (codified as WAC 284-03-990), filed 5/19/75.]

WAC 284-03-99001 Form 276-2—Request for photocopy of record(s).

.....
Request Number
.....
Date Requested
.....
Date Provided
.....
(Office use only)

OFFICE OF INSURANCE COMMISSIONER
Request for Photocopy of Record(s)

Please state below the pages of the documents or records you wish to have photocopied. A reasonable standard fee for each page or record will be charged for this service.

I wish the following page(s) of documents or records to be photocopied and made available for my possession, I agree to pay a reasonable standard charge for this service.

I certify that the photocopies of records received as listed above will not be part of a list of individuals to be used for commercial purposes.

Signed
Date

Office use only

Number of pages copied. @ per copy.
Total charge Amount paid

Insurance
Commissioner
Form 276 - 2
(Page 2 of 2 - Exhibit 2)

[Order R-75-1, Form 276-2 (codified as WAC 284-03-99001), filed 5/19/75.]

Chapter 284-05 WAC
WASHINGTON ACTUARIES REGULATION

WAC

284-05-010	Title.
284-05-020	Purpose.
284-05-030	Scope.
284-05-040	Restriction on signing as actuary.
284-05-050	Actuarial representation.
284-05-060	Qualified actuary defined.
284-05-070	Effective date.

WAC 284-05-010 Title. These rules, WAC 284-05-010 through 284-05-070, shall be known and may be cited as the "Washington actuaries regulation."

[Order R-72-1, § 284-05-010, filed 2/8/72, effective 7/1/72.]

WAC 284-05-020 Purpose. The purpose of this regulation is to establish standards for use of the terms "actuary" or "actuarial." It is not the purpose of this regulation to require any insurer or other person subject to the insurance code to employ an actuary except as may be otherwise required by statute or other administrative rule.

[Order R-72-1, § 284-05-020, filed 2/8/72, effective 7/1/72.]

WAC 284-05-030 Scope. This regulation shall apply to all reports, statements, and other documents filed with the insurance commissioner or issued to the public in relation to the business of insurance.

[Order R-72-1, § 284-05-030, filed 2/8/72, effective 7/1/72.]

WAC 284-05-040 Restriction on signing as actuary. No report, statement, or document shall be filed with the insurance commissioner or issued to the public in relation to the business of insurance if it is signed by a person who represents himself in such instrument to be an actuary unless such person signing as an actuary is a qualified actuary.

[Order R-72-1, § 284-05-040, filed 2/8/72, effective 7/1/72.]

WAC 284-05-050 Actuarial representation. No person in any representation made to the public or to the insurance commissioner in respect to any matter subject to this regulation shall use the word "actuary" or "actuarial" to indicate a degree of professional competence unless such representation was prepared or approved by a qualified actuary.

[Order R-72-1, § 284-05-050, filed 2/8/72, effective 7/1/72.]

WAC 284-05-060 Qualified actuary defined. (1) For the purpose of this regulation, a "qualified actuary" is an individual who in each particular case or assignment is acting within the scope of his or her training, experience and qualifications, and

(a) Is a member of the American Academy of Actuaries, or

(b) Has otherwise demonstrated his or her actuarial competence to the satisfaction of the insurance commissioner, or to the satisfaction of the insurance regulatory official of the domiciliary state of an insurer in the case of any

actuarial certification required in connection with an annual statement filed by such insurer.

(2) Insofar as activities or conduct under the Employee Retirement Income Security Act of 1974 (P.L. 93-406) may be considered to relate to the business of insurance, an "enrolled actuary" pursuant to federal regulations issued under that act shall be deemed a "qualified actuary" with respect to such activities or conduct.

[Order R-76-1, § 284-05-060, filed 2/25/76; Order R-72-1, § 284-05-060, filed 2/8/72, effective 7/1/72.]

WAC 284-05-070 Effective date. The effective date of this regulation shall be July 1, 1972.

[Order R-72-1, § 284-05-070, filed 2/8/72, effective 7/1/72.]

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

WAC**ANNUAL LIABILITY—INSURANCE REPORT**

284-07-010 Special liability insurance report required annually.

ANNUAL AND OTHER STATEMENTS

284-07-050 Annual statement instructions.
284-07-060 Statement of actuarial opinion.
284-07-070 Statements to be filed in electronic form.

AUDITED FINANCIAL STATEMENTS

284-07-100 Purpose and scope.
284-07-110 Definitions.
284-07-120 Filing and extensions for filing of annual audited financial reports.
284-07-130 Contents of annual audited financial report.
284-07-140 Designation of independent certified public accountant.
284-07-150 Qualifications of independent certified public accountant.
284-07-160 Consolidated or combined audits.
284-07-170 Scope of examination and report of independent certified public accountant.
284-07-180 Notification of adverse financial condition.
284-07-190 Report on significant deficiencies in internal controls.
284-07-200 Accountant's letter of qualifications.
284-07-210 Definition, availability, and maintenance of CPA workpapers.
284-07-220 Exemptions and effective dates.
284-07-230 Canadian and British companies.
284-07-310 Purpose.
284-07-320 Authority.
284-07-330 Scope.
284-07-340 Definitions.
284-07-350 General requirements.
284-07-360 Required opinions.
284-07-370 Statement of actuarial opinion not including an asset adequacy analysis.
284-07-380 Statement of actuarial opinion based on an asset adequacy analysis.
284-07-390 Description of actuarial memorandum including an asset adequacy analysis.
284-07-400 Additional considerations for analysis.

DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

284-07-014 Form A for loss and expense exhibit. [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.] Repealed by 94-20-049, filed 9/29/94,

- effective 10/30/94. Statutory Authority: RCW 48.02.060 and 48.05.390.
- 284-07-024 Form B for reporting paid and unpaid losses. [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.] Repealed by 94-20-049, filed 9/29/94, effective 10/30/94. Statutory Authority: RCW 48.02.060 and 48.05.390.
- 284-07-026 Form C for reporting closed and open claims. [Statutory Authority: RCW 48.02.060 and 48.05.380. 89-02-016 (Order R 88-16), § 284-07-026, filed 12/28/88.] Repealed by 94-20-049, filed 9/29/94, effective 10/30/94. Statutory Authority: RCW 48.02.060 and 48.05.390.

ANNUAL LIABILITY—INSURANCE REPORT

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 a form issued by the commissioner.

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

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

(4) Insurers not licensed to write general casualty insurance are exempt from the requirement to submit this report.

(5) Upon the written request of a professional reinsurer which never writes business anywhere on a direct basis, the commissioner may grant such reinsurer a permanent exemption from the requirement to submit this report.

(6) With respect to products liability data, the commissioner finds that comparable information is included in the annual statement required by RCW 48.05.250. Therefore, products liability data shall not be reported on the form required by this section.

[Statutory Authority: RCW 48.02.060 and 48.05.390. 94-20-049, § 284-07-010, filed 9/29/94, effective 10/30/94. 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.]

ANNUAL AND OTHER STATEMENTS

WAC 284-07-050 Annual statement instructions.

(1) Each authorized insurer is required by RCW 48.05.250 to file with the commissioner an annual statement in general form and context as approved by the National Association of Insurance Commissioners (NAIC) for the kinds of insurance to be reported upon, and pursuant to RCW 48.05.400 must also file a copy thereof with the NAIC. To effectuate those statutes and to enhance consistency in the accounting treatment accorded various kinds of insurance transactions, the valuation of assets, and related matters, insurers shall adhere to the appropriate Annual Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC.

(2) This section does not relieve an insurer from its obligation to comply with specific requirements of the insurance code or rules thereunder.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-050, filed 9/9/92, effective 10/10/92.]

WAC 284-07-060 Statement of actuarial opinion.

(1) For purposes of this section "insurer" has the same meaning as set forth in RCW 48.01.050. It also includes a certified health plan registered under chapter 48.43 RCW, health care service contractor registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW.

(2) Each insurer shall include with its annual statement, a statement from a qualified actuary, as defined in WAC 284-05-060, or as defined in subsection (4) of this section for domestic property and casualty insurers, entitled "Statement of Actuarial Opinion," setting forth the actuary's opinion relating to the insurer's reserves and other actuarial items, prepared in accordance with the appropriate *Annual Statement Instructions* and *Accounting Practices and Procedures Manuals* promulgated by the National Association of Insurance Commissioners. If an exemption is allowed by the *Annual Statement Instructions* and is approved by the domiciliary commissioner, an insurer shall be exempt from this requirement (unless the commissioner of Washington makes a specific finding, by order, bulletin, letter, or otherwise, that for a specific insurer, or one or more insurers, company compliance is necessary to carry out the commissioner's statutory responsibilities). A certified copy of the approved exemption must be filed with the annual statement in all jurisdictions in which the company is authorized.

(3) This section does not relieve an insurer from its obligation to comply with other requirements of the insurance code or rules thereunder.

(4) With respect to statements of actuarial opinion for property and casualty insurers domiciled in this state, a person can demonstrate competency in loss reserve evaluation, and thus be considered to be a qualified actuary, only by being:

(a) A member in good standing of the Casualty Actuarial Society; or

(b) A member in good standing of the American Academy of Actuaries who has been approved as qualified for signing casualty loss reserve opinions by the Casualty Practice Council of the American Academy of Actuaries; or

(c) A person with documented experience, skill, and knowledge substantially equivalent to that required for either (a) or (b) of this subsection, acceptable to the commissioner. A person qualifying under this alternative (c) must be approved in advance by the commissioner, as prescribed by the *Annual Statement Instructions*.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-060, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 93-07-020 (Order R 93-1), § 284-07-060, filed 3/8/93, effective 4/8/93.]

WAC 284-07-070 Statements to be filed in electronic form. (1) Annual statements, quarterly statements, and other financial reports filed by an insurer with the National

Association of Insurance Commissioners shall be filed in electronic form as well as on paper.

(2) Until the commissioner otherwise directs by letter, bulletin, or otherwise, generally or as to one or more companies, "electronic form" means, on a diskette.

(3) Until the commissioner otherwise directs by letter, bulletin, or otherwise, generally or as to one or more companies, companies that operate only in Washington need not comply with subsection (1) of this section.

[Statutory Authority: RCW 48.02.060, 93-19-003 (Order R 93-7), § 284-07-070, filed 9/1/93, effective 10/2/93.]

AUDITED FINANCIAL STATEMENTS

WAC 284-07-100 Purpose and scope. (1) The purpose of this regulation, WAC 284-07-100 through 284-07-230, is to improve the Washington state insurance commissioner's surveillance of the financial condition of insurers by requiring an annual examination by independent certified public accountants of the financial statements reporting the financial position and the results of operations of insurers.

(2) Every insurer, as defined in WAC 284-07-110, shall be subject to this regulation. Insurers having direct premiums written of less than one million dollars in any calendar year and less than one thousand policyholders or certificate holders of directly written policies nation-wide at the end of such calendar year shall be exempt from this rule for such year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of one million dollars or more will not be so exempt.

(3) Foreign or alien insurers filing audited financial reports in another state, pursuant to such other state's requirement of audited financial reports which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from this rule if:

(a) A copy of the Audited Financial Report, Report on Significant Deficiencies in Internal Controls, and the Accountant's Letter of Qualifications which are filed with such other state are filed with the commissioner in accordance with the filing dates specified in WAC 284-07-120, 284-07-190 and 284-07-200, respectively; and

(b) A copy of any Notification of Adverse Financial Condition Report filed with such other state is filed with the commissioner within the time specified in WAC 284-07-180.

Canadian insurers may submit accountants' reports as filed with the Canadian Dominion Department of Insurance.

(4) This rule shall not prohibit, preclude, or in any way limit the commissioner from ordering, conducting, or performing examinations of insurers under the rules, regulations, practices, and procedures of the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200, 94-04-045 (Order R 94-2), § 284-07-100, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060, 92-19-040 (Order R 92-10), § 284-07-100, filed 9/9/92, effective 10/10/92.]

WAC 284-07-110 Definitions. For the purposes of this regulation the following definitions shall apply:

(1) "Audited financial report" means and includes those items specified in WAC 284-07-130.

(2) "Accountant" and "independent certified public accountant" mean an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which they are licensed to practice; for Canadian and British companies, the terms mean a "Canadian-chartered or British-chartered accountant."

(3) "Insurer" has the same meaning as set forth in RCW 48.01.050. It also includes a certified health plan registered under chapter 48.43 RCW, health care service contractor registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW.

(4) "NAIC" means National Association of Insurance Commissioners.

(5) "Policy holder" shall also mean subscriber.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200, 94-04-045 (Order R 94-2), § 284-07-110, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060, 92-19-040 (Order R 92-10), § 284-07-110, filed 9/9/92, effective 10/10/92.]

WAC 284-07-120 Filing and extensions for filing of annual audited financial reports. (1) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety days advance notice to the insurer.

(2) Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

[Statutory Authority: RCW 48.02.060, 92-19-040 (Order R 92-10), § 284-07-120, filed 9/9/92, effective 10/10/92.]

WAC 284-07-130 Contents of annual audited financial report. (1) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the commissioner.

(2) The annual audited financial report shall include the following:

- (a) Report of independent certified public accountant.
- (b) Balance sheet reporting admitted assets, liabilities, capital, and surplus.
- (c) Statement of operations.
- (d) Statement of cash flows.
- (e) Statement of changes in capital and surplus.

(f) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and any other notes required by generally accepted accounting principles and shall also include:

(i) A reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to RCW 48.05.250, 48.43.050, 48.44.095, or 48.46.080 with a written description of the nature of these differences.

(ii) A summary of ownership and relationships of the insurer and all affiliated companies.

(g) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statements shall be comparative, presenting the amounts as of December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-130, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-130, filed 9/9/92, effective 10/10/92.]

WAC 284-07-140 Designation of independent certified public accountant. (1) Each insurer required by this regulation to file an annual audited financial report must, within sixty days after becoming subject to such requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit required by this regulation. Each insurer not retaining an independent certified public accountant on the effective date of this rule, or the date on which this rule becomes applicable to it, shall register the name and address of their retained certified public accountant not less than two months before the date when the first audited financial report is to be filed.

(2) The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the Washington state insurance code, Title 48, and the rules and regulations thereunder, that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the commissioner, specifying such exceptions as are believed appropriate.

(3) If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall, within five business days, notify the commissioner of this event. The insurer shall also furnish the commissioner with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him to make reference to the subject matter of the disagreement in connection with his opinion. The disagreements required to be reported

in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request such former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for disagreement; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-140, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-140, filed 9/9/92, effective 10/10/92.]

WAC 284-07-150 Qualifications of independent certified public accountant. (1) The commissioner shall not recognize any person or firm as a qualified independent certified public accountant that is not in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant.

(2) Except as otherwise provided herein, an independent certified public accountant shall be recognized as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and the code of professional conduct of the state of Washington board of public accountancy, or similar applicable code.

(3) No partner or other person responsible for rendering a report may act in that capacity for more than seven consecutive years. Following any period of service such person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of two years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. The commissioner may consider the following factors in determining if the relief should be granted:

- (a) Number of partners, expertise of the partners, or the number of insurance clients in the currently registered firm;
- (b) Premium volume of the insurer; and
- (c) Number of jurisdictions in which the insurer transacts business.

The requirements of this subsection shall become effective two years after the enactment of this regulation.

(4) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept any annual audited financial report, prepared in whole or in part by, any natural person who:

- (a) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961-1968, or any dishonest conduct or practices under federal or state law;

(b) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or

(c) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this rule.

(5) The commissioner as provided in RCW 48.02.060 may hold a hearing to determine whether a certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-150, filed 9/9/92, effective 10/10/92.]

WAC 284-07-160 Consolidated or combined audits.

An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet.

(2) Amounts for each insurer subject to this section shall be stated separately.

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis.

(4) Explanations of consolidating and eliminating entries shall be included.

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-160, filed 9/9/92, effective 10/10/92.]

WAC 284-07-170 Scope of examination and report of independent certified public accountant. Financial statements furnished pursuant to WAC 284-07-130 hereof shall be examined by an independent certified public accountant. The examination of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. Consideration should also be given to such other procedures illustrated in the Financial Condition Examiner's Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-170, filed 9/9/92, effective 10/10/92.]

WAC 284-07-180 Notification of adverse financial condition. (1) The insurer required to furnish the annual audited financial report shall require the independent

certified public accountant to report, in writing, within five business days to the board of directors or its audit committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination or that the insurer does not meet the minimum capital and surplus or net worth requirements of the Washington state insurance code as of that date. An insurer who has received a report pursuant to this subsection shall forward a copy of the report to the commissioner within five business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five business day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five business days.

(2) No independent public accountant shall, by virtue of this regulation, be liable in any manner to any person for any statement made in connection with subsection (1) of this section if such statement is made in good faith in compliance with subsection (1) of this section.

(3) If the accountant, subsequent to the date of the audited financial report filed pursuant to this regulation, becomes aware of facts which might have affected his or her report, the accountant should take such action as is prescribed in Volume 1, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-180, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-180, filed 9/9/92, effective 10/10/92.]

WAC 284-07-190 Report on significant deficiencies in internal controls. In addition to the annual audited financial statements, each insurer shall furnish the commissioner with a written report prepared by the accountant describing significant deficiencies in the insurer's internal control structure noted by the accountant during the audit. SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants) requires an accountant to communicate significant deficiencies (known as "reportable conditions") noted during a financial statement audit to the appropriate parties within an entity. No report should be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the written report shall be filed annually by the insurer with the commissioner within sixty days after the filing of the annual audited financial statements. The insurer is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-190, filed 9/9/92, effective 10/10/92.]

WAC 284-07-200 Accountant's letter of qualifications. The accountant shall furnish the insurer in connection

with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and the rules of professional conduct of the Washington board of public accountancy, or similar applicable rules.

(2) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this rule shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards.

(3) That the accountant understands the annual audited financial report and the opinion thereon will be filed in compliance with this rule and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers.

(4) That the accountant consents to the requirements of WAC 284-07-210 and that the accountant consents and agrees to make available for review by the commissioner or his designee the workpapers, as defined in WAC 284-07-210.

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants.

(6) A representation that the accountant is in compliance with the requirements of WAC 284-07-150.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-200, filed 9/9/92, effective 10/10/92.]

WAC 284-07-210 Definition, availability, and maintenance of CPA workpapers. (1) Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the examination of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the examination of the financial statements of an insurer and which support the accountant's opinion thereof.

(2) Every insurer required to file an audited financial report pursuant to this regulation, shall require the accountant to make available for review by the commissioner's examiners, all workpapers prepared in the conduct of the examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the commissioner's office or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the commissioner has filed a report on

examination covering the period of the audit but no longer than seven years from the date of the audit report.

(3) In the conduct of the aforementioned periodic review by the commissioner's examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the commissioner's office. Such reviews by the commissioner's examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the insurance commissioner.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-210, filed 9/9/92, effective 10/10/92.]

WAC 284-07-220 Exemptions and effective dates.

(1) Upon written application of any insurer, the commissioner may grant an exemption from compliance with this regulation if the commissioner finds, upon review of the application, that compliance would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this regulation, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the rules and procedures pertaining to administrative hearings.

(2) Domestic insurers retaining a certified public accountant on the effective date of this regulation who qualifies as independent shall comply with this regulation for the year ending December 31, 1992, and each year thereafter unless the commissioner permits otherwise.

(3) Domestic insurers not retaining a certified public accountant on the effective date of this regulation who qualify as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(a) As of December 31, 1992, file with the commissioner:

- (i) Report of independent certified public accountant;
- (ii) Audited balance sheet;
- (iii) Notes to audited balance sheet.

(b) For the year ending December 31, 1992, and each year thereafter, such insurers shall file with the commissioner all reports required by this regulation.

(4) Foreign insurers shall comply with this regulation for the year ending December 31, 1992, and each year thereafter, unless the commissioner permits otherwise.

(5) An insurer who on December 31, 1993, was not subject to WAC 284-07-100 through 284-07-230, and who on that date retained a certified public accountant, who is qualified as independent, shall comply with this regulation for the year ending December 31, 1993, and each year thereafter unless the commissioner permits by order, bulletin, letter, or otherwise, for a specific insurer or any one or more insurers.

(6) An insurer who on December 31, 1993, was not subject to WAC 284-07-100 through 284-07-230, and who on that date did not retain a certified public accountant, who is qualified as independent, shall meet the following minimum schedule for compliance unless the commissioner

permits by order, bulletin, letter, or otherwise, for a specific insurer or any one or more insurers.

(a) As of December 31, 1993, file with the commissioner by June 1, 1994:

- (i) Report of independent certified public accountant;
- (ii) Audited balance sheet;
- (iii) Notes to audited balance sheet.

(b) And, for the year ending December 31, 1994, and each year thereafter, such insurers shall file with the commissioner all reports required by this regulation.

[Statutory Authority: RCW 48.02.060, 48.43.140, 48.44.050 and 48.46.200. 94-04-045 (Order R 94-2), § 284-07-220, filed 1/27/94, effective 2/27/94. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-220, filed 9/9/92, effective 10/10/92.]

WAC 284-07-230 Canadian and British companies.

(1) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their domiciliary supervision authority duly audited by an independent chartered accountant.

(2) For such insurers, the letter required in WAC 284-07-140(2) shall state that the accountant is aware of the requirements relating to the annual audited statement filed with the commissioner pursuant to WAC 284-07-120 and shall affirm that the opinion expressed is in conformity with such requirements.

[Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-230, filed 9/9/92, effective 10/10/92.]

WAC 284-07-310 Purpose. The purpose of this regulation, WAC 284-07-310 through and including WAC 284-07-400, is to prescribe:

(1) Guidelines and standards for statements of actuarial opinion that are to be submitted in accordance with RCW 48.74.025, 48.36A.250, 48.36A.260, and for memoranda in support thereof;

(2) Guidelines and standards for statements of actuarial opinion which are to be submitted when a company is exempt from RCW 48.74.025(2); and

(3) Rules applicable to the appointment of an appointed actuary.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-310, filed 12/30/94, effective 1/30/95.]

WAC 284-07-320 Authority. This regulation is issued pursuant to the authority vested in the commissioner under RCW 48.01.030, 48.02.060, and chapters 48.36A and 48.74 RCW.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-320, filed 12/30/94, effective 1/30/95.]

WAC 284-07-330 Scope. (1) This regulation applies to all life insurance companies and fraternal benefit societies doing business in this state, to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities, or disability insurance business in this state; and to all disability insurers that file annual statements on the life and accident and health blank.

(2) This regulation applies to all annual statements filed with the commissioner after the effective date of this regulation. Except with respect to companies which are exempted pursuant to WAC 284-07-360, a statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with WAC 284-07-380, and a memorandum in support thereof in accordance with WAC 284-07-390, shall be required each year. Any company so exempted must file a statement of actuarial opinion pursuant to WAC 284-07-370.

(3) Notwithstanding the foregoing, the commissioner may require any company otherwise exempt pursuant to this regulation to submit a statement of actuarial opinion and to prepare a memorandum in support thereof in accordance with WAC 284-07-380 and 284-07-390 if, in the opinion of the commissioner, an asset adequacy analysis is necessary with respect to the company.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-330, filed 12/30/94, effective 1/30/95.]

WAC 284-07-340 Definitions. (1) "Actuarial opinion" means:

(a) With respect to WAC 284-07-380, 284-07-390, or 284-07-400, the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy test in accordance with WAC 284-07-380 and with presently accepted actuarial standards;

(b) With respect to WAC 284-07-370, the opinion of an appointed actuary regarding the calculation of reserves and related items, in accordance with WAC 284-07-370 and with those presently accepted actuarial standards which specifically relate to this opinion.

(2) "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(3) "Annual statement" means that statement required by RCW 48.05.250 to be filed annually by the company with the commissioner.

(4) "Appointed actuary" means any individual who is appointed or retained in accordance with the requirements set forth in WAC 284-07-350(3) to provide the actuarial opinion and supporting memorandum as required by RCW 48.74.025.

(5) "Asset adequacy analysis" means an analysis that meets the standards and other requirements referred to in WAC 284-07-350(4); it may take many forms, including, but not limited to, cash flow testing, sensitivity testing, or applications of risk theory.

(6) "Company" means an insurance company, fraternal benefit society, or reinsurer subject to this regulation.

(7) "Noninvestment-grade bonds" means those bonds designated as classes 3, 4, 5, or 6 by the National Association of Insurance Commissioners (NAIC) Securities Valuation Office (SVO).

(8) "Qualified actuary" means an individual who meets the requirements set forth in WAC 284-07-350(2).

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-340, filed 12/30/94, effective 1/30/95.]

WAC 284-07-350 General requirements. (1) Submission of statement of actuarial opinion.

(a) There is to be included on or attached to page 1 of the annual statement for each year beginning with the annual statement for 1994, the statement of an appointed actuary, entitled "statement of actuarial opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with WAC 284-07-380: *Provided, however,* That any company exempted pursuant to WAC 284-07-360 from submitting a statement of actuarial opinion in accordance with WAC 280-07-380 shall include on or attach to page 1 of the annual statement a statement of actuarial opinion rendered by an appointed actuary in accordance with WAC 284-07-370.

(b) If in the previous year a company provided a statement of actuarial opinion in accordance with WAC 284-07-370, and in the current year fails the exemption criteria of WAC 284-07-360 (3)(a), (b), or (c) to again provide an actuarial opinion in accordance with WAC 284-07-370, the statement of actuarial opinion in accordance with WAC 284-07-380 shall not be required until August 1 following the date of the annual statement. In this instance, the company shall provide a statement of actuarial opinion in accordance with WAC 284-07-370 with appropriate qualification noting the intent to subsequently provide a statement of actuarial opinion in accordance with WAC 284-07-380.

(c) In the case of a statement of actuarial opinion required to be submitted by a foreign or alien company, the commissioner may accept the statement of actuarial opinion filed by such company with the insurance supervisory regulator of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(d) Upon written request by the company, the commissioner may grant an extension of the date for submission of the statement of actuarial opinion.

(2) "Qualified actuary" means an individual who:

(a) Is a member in good standing of the American Academy of Actuaries; and

(b) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements or equivalent standards acceptable to the commissioner; and

(c) Is familiar with the valuation requirements applicable to life and health insurance companies; and

(d) Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice to have:

(i) Violated any provision of, or any obligation imposed by, Title 48 RCW or other law or any applicable regulation or order of the commissioner in the course of his or her dealings as a qualified actuary;

(ii) Been found guilty of fraudulent or dishonest practices;

(iii) Demonstrated his or her incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(iv) Submitted to the commissioner during the past five years, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this

regulation or standards set by the Actuarial Standards Board; or

(v) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(e) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under (d) of this subsection.

(f) The commissioner may accept equivalent qualifications in place of those in (a) and (b) of this subsection if the individual has otherwise demonstrated his or her actuarial competence to the satisfaction of the commissioner, and meets the qualifications in (c), (d), and (e) of this subsection.

(3) "Appointed actuary" means a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this regulation; either directly by, or by the authority of, the board of directors through an executive officer of the company. The company shall give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements set forth in subsection (2) of this section. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in subsection (2) of this section. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement.

(4) Standards for asset adequacy analysis: Except to the extent the commissioner approves equivalents in advance, the asset adequacy analysis required by this regulation:

(a) Shall conform to the standards of practice as promulgated from time to time by the Actuarial Standards Board and to any additional standards under this regulation, which standards are to form the basis of the statement of actuarial opinion in accordance with WAC 284-07-380; and

(b) Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board.

(5) Liabilities to be covered.

(a) Under authority of RCW 48.74.025, the statement of actuarial opinion shall apply to all in force business on the statement date regardless of when or where issued, e.g., reserves of Exhibits 8, 9, and 10, and claim liabilities in Exhibit 11, Part 1 and equivalent items in the separate account statement or statements.

(b) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in RCW 48.74.040, 48.74.070, 48.74.080, and 48.74.090, the company shall establish such additional reserve.

(c) For years ending prior to December 31, 1995, the company may, in lieu of establishing the full amount of the additional reserve in the annual statement for that year, set

up an additional reserve in an amount not less than two times the additional reserve divided by three.

(d) Additional reserves established under (b) or (c) of this subsection and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-350, filed 12/30/94, effective 1/30/95.]

WAC 284-07-360 Required opinions. (1) In accordance with RCW 48.74.025, every company doing business in this state shall annually submit the opinion of an appointed actuary as provided for by this regulation. The type of opinion submitted shall be determined by the provisions set forth in this section and shall be in accordance with the applicable provisions in this regulation.

(2) Company categories. For purposes of this regulation, companies shall be classified as follows based on the admitted assets as of the end of the calendar year for which the actuarial opinion is applicable:

(a) Category A shall consist of those companies whose admitted assets do not exceed twenty million dollars;

(b) Category B shall consist of those companies whose admitted assets exceed twenty million dollars but do not exceed one hundred million dollars;

(c) Category C shall consist of those companies whose admitted assets exceed one hundred million dollars but do not exceed five hundred million dollars; and

(d) Category D shall consist of those companies whose admitted assets exceed five hundred million dollars.

(3) Exemption eligibility tests:

(a) Any Category A company that, for any year beginning with 1994, meets all of the following criteria shall be eligible for exemption from submission of a statement of actuarial opinion in accordance with WAC 284-07-380 for the year in which these criteria are met. The ratios in (a)(i), (ii), and (iii) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable.

(i) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .10.

(ii) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .30.

(iii) The ratio of the book value of the noninvestment-grade bonds to the sum of capital and surplus is less than .50.

(iv) The Examiner Team for the NAIC has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile and the commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC Staff and Support Office (SSO).

(b) Any Category B company that, for any year beginning with 1994, meets all of the following criteria shall be eligible for exemption from submission of a statement of actuarial opinion in accordance with WAC 284-07-380 for the year in which the criteria are met. The ratios in (b)(i), (ii), and (iii) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable.

(i) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .07.

(ii) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .40.

(iii) The ratio of the book value of the noninvestment-grade bonds to the sum of capital and surplus is less than .50.

(iv) The Examiner Team for the NAIC has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile and the commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC SSO.

(c) Any Category A or Category B company that meets all of the criteria set forth in (a) or (b) of this subsection, whichever is applicable, is exempted from submission of a statement of actuarial opinion in accordance with WAC 284-07-380 unless the commissioner specifically indicates to the company that the exemption is not to be taken.

(d) Any Category A or Category B company that for any year beginning with 1994 is not exempted under (c) of this subsection, shall be required to submit a statement of actuarial opinion in accordance with WAC 284-07-380 for the year for which it is not exempt.

(e) Any Category C company that, after submitting an opinion in accordance with WAC 284-07-380 meets all of the following criteria shall not be required, unless required in accordance with (f) of this subsection, to submit a statement of actuarial opinion in accordance with WAC 284-07-380 more frequently than every third year. Any Category C company which fails to meet all of the following criteria for any year shall submit a statement of actuarial opinion in accordance with WAC 284-07-380 for that year. The ratios in (e)(i), (ii) and (iii) of this subsection shall be calculated based on amounts as of the end of the calendar year for which the actuarial opinion is applicable.

(i) The ratio of the sum of capital and surplus to the sum of cash and invested assets is at least equal to .05;

(ii) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is less than .50;

(iii) The ratio of the book value of the noninvestment-grade bonds to the sum of the capital and surplus is less than .50;

(iv) The Examiner Team for the NAIC has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year

for which the actuarial opinion is applicable, or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile and the commissioner has so notified the chair of the NAIC Life and Health Actuarial Task Force and the NAIC SSO.

(f) Any company which is not required by this section to submit a statement of actuarial opinion in accordance with WAC 284-07-380 for any year shall submit a statement of actuarial opinion in accordance with WAC 284-07-370 for that year unless as provided for by WAC 284-07-330(3) the commissioner requires a statement of actuarial opinion in accordance with WAC 284-07-380.

(4) Every Category D company shall submit a statement of actuarial opinion in accordance with WAC 284-07-380 for each year beginning with the year 1994.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-360, filed 12/30/94, effective 1/30/95.]

WAC 284-07-370 Statement of actuarial opinion not including an asset adequacy analysis. (1) The statement of actuarial opinion required by this section shall consist of:

(a) A paragraph identifying the appointed actuary and his or her qualifications;

(b) A regulatory authority paragraph stating that the company is exempt pursuant to this regulation from submitting a statement of actuarial opinion based on an asset adequacy analysis and that the opinion, which is not based on an asset adequacy analysis, is rendered in accordance with this section;

(c) A scope paragraph identifying the subjects on which the opinion is to be expressed and describing the scope of the appointed actuary's work; and

(d) An opinion paragraph expressing the appointed actuary's opinion as required by RCW 48.74.025.

(2) Recommended language: The following language provided is that which in typical circumstances shall be included in a statement of actuarial opinion in accordance with this section. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary shall use language which clearly expresses his or her professional judgment. The opinion shall retain all pertinent aspects of the language provided in this section.

(a) The opening paragraph shall indicate the appointed actuary's relationship to the company.

(i) For a company actuary, the opening paragraph of the actuarial opinion shall read substantially as follows:

"I, [name of actuary], am [title] of [name of company] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of that insurer to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability companies."

(ii) For a consulting actuary, the opening paragraph of the actuarial opinion shall include a statement substantially as follows:

"I, [name and title of actuary], a member of the American Academy of Actuaries, am associated with the firm

of [insert name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability insurance companies."

(b) The regulatory authority paragraph shall include a statement substantially as follows: "The company is exempt pursuant to WAC 284-07-310 through 284-07-400 from submitting a statement of actuarial opinion based on an asset adequacy analysis. This opinion, which is not based on an asset adequacy analysis, is rendered in accordance with WAC 284-07-370."

(c) The scope paragraph shall contain a sentence substantially as follows: "I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, []". The paragraph shall list items and amounts with respect to which the appointed actuary is expressing an opinion. The list shall include but not necessarily be limited to:

(i) Aggregate reserve and deposit funds for policies and contracts included in Exhibit 8;

(ii) Aggregate reserve and deposit funds for policies and contracts included in Exhibit 9;

(iii) Deposit funds, premiums, dividend and coupon accumulations, and supplementary contracts not involving life contingencies included in Exhibit 10;

(iv) Net deferred and uncollected premiums for which the full annual mean tabular reserve liability is carried in Exhibit 8;

(v) Policy and contract claims—liability end of current year included in Exhibit 11, Part 1; and

(vi) "Cost of collection" in excess of loading.

(d) If the appointed actuary has examined the underlying records, the scope paragraph shall also include substantially the following statement:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic records and such tests of the actuarial calculations as I considered necessary."

(e) If the appointed actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force prepared by the company or a third party, the scope paragraph shall include a statement substantially similar to one of the following:

(i) "I have relied upon listings and summaries of policies and contracts and other liabilities in force prepared by [name and title of company officer certifying in force records] as certified in the attached statement. (See accompanying affidavit by a company officer.) In other respects my examination included review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary."

(ii) "I have relied upon [name of accounting firm] for the substantial accuracy of the in force records inventory and information concerning other liabilities, as certified in the attached statement. In other respects my examination included review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary."

(iii) The statement of the person certifying shall follow the form indicated by (j) of this subsection.

(f) The opinion paragraph shall include substantially the following statement:

"In my opinion the amounts carried in the balance sheet on account of the actuarial items identified above:

- (i) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;
- (ii) Are based on actuarial assumptions which produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;
- (iii) Meet the requirements of the insurance laws and regulations of the state of [state of domicile] and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;
- (iv) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end with any exceptions as noted below; and
- (v) Include provision for all actuarial reserves and related statement items which ought to be established.

The actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice and Compliance Guidelines as promulgated by the Actuarial Standards Board, which standards and guidelines form the basis of this statement of opinion."

(g) The concluding paragraph shall document the eligibility for the company to provide an opinion as provided by this section. It shall include substantially the following statement:

"This opinion is provided in accordance with WAC 284-07-370. As such it does not include an opinion regarding the adequacy of reserves and related actuarial items when considered in light of the assets which support them.

Eligibility for WAC 284-07-370 is confirmed as follows:

- (i) The ratio of the sum of capital and surplus to the sum of cash and invested assets is [insert amount], which equals or exceeds the applicable criterion based on the admitted assets of the company (WAC 284-07-360(3)).

(ii) The ratio of the sum of the reserves and liabilities for annuities and deposits to the total admitted assets is [insert amount], which is less than the applicable criteria based on the admitted assets of the company (WAC 284-07-360(3)).

(iii) The ratio of the book value of the noninvestment-grade bonds to the sum of capital and surplus is [insert amount], which is less than the applicable criteria of .50.

(iv) To my knowledge, the NAIC Examiner Team has not designated the company as a first priority company in any of the two calendar years preceding the calendar year for which the actuarial opinion is applicable, or a second priority company in each of the two calendar years preceding the calendar year for which the actuarial opinion is applicable or the company has resolved the first or second priority status to the satisfaction of the commissioner of the state of domicile.

(v) To my knowledge there is not a specific request from any Commissioner requiring an asset adequacy analysis opinion.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary"

(h) If there has been any change in the actuarial assumptions from those previously employed, that change shall be described in the annual statement or in a paragraph of the statement of actuarial opinion; and the reference in (f)(iv) of this section to consistency shall read substantially as follows:

". . . with the exception of the change described on Page [] of the annual statement (or in the preceding paragraph)."

The adoption for new issues or new claims or other new liabilities of an actuarial assumption which differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this paragraph.

(i) If the appointed actuary is unable to form an opinion, he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for such opinion. This statement shall follow the scope paragraph and precede the opinion paragraph.

(j) If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force, there shall be attached to the opinion, the statement of a company officer or accounting firm who prepared such underlying data similar to the following:

"I [name of officer], [title] of [name and address of company or accounting firm], hereby affirm that the listings and summaries of policies and contracts in force as of December 31, [], prepared for and submitted to [name of appointed actuary], were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

Signature of the Officer of the Company
or Accounting Firm

Address of the Officer of the Company
or Accounting Firm

Telephone Number of the Officer of the
Company or Accounting Firm"

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-370, filed 12/30/94, effective 1/30/95.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-07-380 Statement of actuarial opinion based on an asset adequacy analysis. (1) The statement of actuarial opinion submitted in accordance with this section shall consist of:

(a) A paragraph identifying the appointed actuary and his or her qualifications (see subsection (2)(a) of this section);

(b) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items which have been analyzed for asset adequacy and the method of analysis, (see subsection (2)(b) of this section) and identifying the reserves and related actuarial items covered by the opinion which have not been so analyzed;

(c) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see subsection (2)(c) of this section), supported by a statement of each such expert in the form prescribed by subsection (5) of this section; and

(d) An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see subsection (2)(f) of this section).

(e) One or more additional paragraphs may be appropriate in individual company cases, as follows:

(i) If the appointed actuary considers it necessary to state a qualification of his or her opinion;

(ii) If the appointed actuary must disclose the method of aggregation for reserves of different products or lines of business for asset adequacy analysis;

(iii) If the appointed actuary must disclose reliance upon any portion of the assets supporting the asset valuation reserve (AVR), interest maintenance reserve (IMR), or other

mandatory or voluntary statement of reserves for asset adequacy analysis;

(iv) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(v) If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release; or

(vi) If the appointed actuary chooses to add a paragraph briefly describing the assumptions which form the basis for the actuarial opinion.

(2) Recommended language: The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances shall be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary shall use language which clearly expresses his or her professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section.

(a) The opening paragraph shall generally indicate the appointed actuary's relationship to the company and his or her qualifications to sign the opinion.

(i) For a company actuary, the opening paragraph of the actuarial opinion shall read substantially as follows:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of that insurer to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability insurance companies."

(ii) For a consulting actuary, the opening paragraph shall contain a statement substantially similar to the following:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability insurance companies."

(b) The scope paragraph shall include a statement substantially similar to the following:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 19 []. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

Asset Adequacy Tested Amounts				Reserves and Liabilities	
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1) + (2) + (3) (4)
Exhibit 8					
A Life Insurance					
B Annuities					
C Supplementary Contracts Involving Life Contingencies					
D Accidental Death Benefit					
E Disability - Active					
F Disability - Disabled					
G Miscellaneous					
Total (Exhibit 8 Item 1, Page 3)					
Exhibit 9					
A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 9 Item 2, Page 3)					
Exhibit 10					
1 Premiums and Other Deposit Funds					
1.1 Policyholder Premiums (Page 3, Line 10.1)					
1.2 Guaranteed Interest Contracts (Page 3, Line 10.2)					
1.3 Other Contract Deposit Funds (Page 3, Line 10.3)					

Asset Adequacy Tested Amounts				Reserves and Liabilities	
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
2 Supplementary Contracts Not Involving Life Contingencies (Page 3, Line 3)					
3 Dividend and Coupon Accumulations (Page 3, Line 5)					
Total Exhibit 10					
Exhibit 11 Part 1					
1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Life 4.2)					
Total Exhibit 11, Part 1					
Separate Accounts (Page 3, Line 27)					
TOTAL RESERVES					

IMR (Page 3 Line 11.4)	
AVR (Page 3 Line 24.1)	(c)

Notes to table of reserves and related actuarial items:

Page and line numbers refer to the 1992 blank. Corresponding entries from blanks from later years shall be substituted as appropriate.

- (a) The additional actuarial reserves are the reserves established under WAC 284-07-350 (5)(b) or (c).
- (b) The appointed actuary shall indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in WAC 284-07-350(4), by means of symbols which shall be defined in footnotes to the table.
- (c) Allocated amount."

(c) If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph shall include a statement substantially similar to one of the following:

- (i) "I have relied on [name], [title] for [e.g., anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios] and, as certified in the attached statement, . . ."
- (ii) "I have relied on personnel as cited in the supporting memorandum for certain critical aspects of the analysis in reference to the accompanying statement."

A statement of reliance on other experts should be accompanied by a statement by each of such experts of the form prescribed by subsection (5) of this section.

(d) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph shall also include substantially the following statement:

"My examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic asset and liability records and such tests of the actuarial calculations as I considered necessary."

(e) If the appointed actuary has not examined the underlying records, but has relied upon listings and summaries of policies in force or asset records or both prepared by the company or a third party, the reliance paragraph shall include a statement substantially similar to one of the following:

- (i) "I have relied upon listings and summaries [of policies and contracts, of asset records] prepared by [name and title of company officer certifying in-force records] as certified in the attached statement. In other respects my examination included such review of the actuarial assumptions and actuarial methods and such tests of the actuarial calculations as I considered necessary."
- (ii) "I have relied upon [name of accounting firm] for the substantial accuracy of the in-force records inventory and information concerning other liabilities, as certified in the attached statement. In other respects my examination included review of the actuarial assumptions and actuarial methods and

tests of the actuarial calculations as I considered necessary."

Such a section shall be accompanied by a statement by each person relied upon based on the form prescribed by subsection (5) of this section.

(f) The opinion paragraph shall include a statement substantially similar to the following:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

- (i) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;
- (ii) Are based on actuarial assumptions which produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;
- (iii) Meet the requirements of the insurance laws and regulations of the state of [state of domicile] and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;
- (iv) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below);
- (v) Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

or

The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion.

The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

best of my knowledge and belief, are substantially accurate and complete.

Signature of Appointed Actuary

Signature of the Officer of the Company,
Accounting Firm or the Security Analyst

Address of Appointed Actuary

Address of the Officer of the Company,
Accounting Firm or the Security Analyst

Telephone Number of Appointed Actuary"

Telephone Number of the Officer of the
Company, Accounting Firm or
the Security Analyst"

(3) Assumptions for new issues: The adoption for new issues or new claims or other new liabilities of an actuarial assumption which differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this section.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-380, filed 12/30/94, effective 1/30/95.]

(4) Adverse opinions: If the appointed actuary is unable to form an opinion, then he or she shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for such opinion. This statement should follow the scope paragraph and precede the opinion paragraph.

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

(5) Reliance on data furnished by other persons. If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force or asset-oriented information, there shall be attached to the opinion the statement of a company officer or accounting firm who prepared such underlying data, substantially similar to either or both of the following, as appropriate:

WAC 284-07-390 Description of actuarial memorandum including an asset adequacy analysis. (1)(a) In accordance with RCW 48.74.025, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves under a WAC 284-07-380 opinion. The memorandum shall be made available for examination by the commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the commissioner or subject to automatic filing with the commissioner.

(a) "I [name of officer], [title], of [name of company or accounting firm], hereby affirm that the listings and summaries of policies and contracts in force as of December 31, 19[], and other liabilities prepared for and submitted to [name of appointed actuary] were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

(b) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of WAC 284-07-350(2), with respect to the areas covered in such memoranda, and shall so state in their memoranda.

Signature of the Officer of the Company
or Accounting Firm

(c) If the commissioner requests a memorandum and an adequate memorandum is not provided within ten days of the request, or, if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the commissioner may designate a qualified actuary to review the opinion and prepare the supporting memorandum required for review. All reasonable and necessary expenses of the independent review shall be paid by the company but all expenses connected therewith shall be directed and controlled by the commissioner.

Address of the Officer of the Company
or Accounting Firm

(d)(i) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the commissioner: *Provided, however,* That any information provided by the company to the reviewing actuary and included in the work papers shall be considered material provided by the company to the commissioner and shall be kept confidential to the same extent as prescribed by law with respect to other material provided by the company to the commissioner pursuant to the statute governing this regulation.

Telephone Number of the Officer of the
Company or Accounting Firm"

(b) "I, [name of officer], [title] of [name of company, accounting firm, or security analyst], hereby affirm that the listings, summaries, and analyses relating to data prepared for and submitted to [name of appointed actuary] in support of the asset-oriented aspects of the opinion were prepared under my direction and, to the

(ii) The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for the current year or any one of the preceding three years.

(2) When an actuarial opinion under WAC 284-07-380 is provided, the memorandum shall demonstrate that the analysis has been completed in accordance with the standards for asset adequacy referred to in WAC 284-07-350(4) and any additional standards required by the commissioner. The memorandum shall specify:

(a) For reserves:

(i) Product descriptions including market description, underwriting and other aspects of a risk profile, and the specific risks the appointed actuary deems significant;

(ii) Sources of liabilities in force;

(iii) Reserve methods and bases;

(iv) Investment reserves;

(v) Reinsurance arrangements.

(b) For assets:

(i) Portfolio descriptions, including a risk profile disclosing the quality, distribution, and types of assets;

(ii) Investment and disinvestment assumptions;

(iii) Sources of asset data;

(iv) Asset valuation bases.

(c) Analysis basis:

(i) Methodology;

(ii) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;

(iii) Rationale for degree of rigor in analyzing different blocks of business;

(iv) Criteria for determining asset adequacy;

(v) Effect of federal income taxes, reinsurance, and other relevant factors.

(d) Assumptions:

(i) Lapse rates, including a comparison of assumed lapse rates with actual lapse rates, if lapse experience studies have been performed;

(ii) Interest crediting rate strategy;

(iii) Mortality rates, either specified directly or stated with reference to nonproprietary, published tables;

(iv) Dividend strategy;

(v) Competitor or market interest rate;

(vi) Annuitization rates;

(vii) Commissions and expenses, including a comparison of assumptions with recent actual commissions and expenses;

(viii) Asset default costs;

(ix) Bond call function;

(x) Mortgage prepayment function;

(xi) Determination of market value for assets sold due to disinvestment strategy;

(xii) Anticipated yield on assets acquired through the investment strategy.

(e) Impact of changes in assumptions used in asset adequacy analysis, based on sensitivity tests performed.

(f) Results:

(i) Schedules under each required scenario showing the cash flows by each of the major items of income, benefits, and expenses, statutory gains or losses, and statutory balance sheet, as modeled, for each year in the projection period: *Provided however*, That for 1994, abbreviated schedules,

appropriate in the judgment of the appointed actuary, are acceptable.

(ii) Summary of results.

(g) Conclusion(s).

(3) The memorandum shall include a statement substantially similar to the following:

"Actuarial methods, considerations, and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-390, filed 12/30/94, effective 1/30/95.]

WAC 284-07-400 Additional considerations for analysis. (1) Aggregation: For the asset adequacy analysis for the statement of actuarial opinion provided in accordance with WAC 284-07-380, reserves and assets may be aggregated by either of the following methods:

(a) Aggregate the reserves and related actuarial items, and the supporting assets, for different products or lines of business, before analyzing the adequacy of the combined assets to mature the combined liabilities. The appointed actuary must be satisfied that the assets held in support of the reserves and related actuarial items so aggregated are managed in such a manner that the cash flows from the aggregated assets are available to help mature the liabilities from the blocks of business that have been aggregated.

(b) Aggregate the results of asset adequacy analysis of one or more products or lines of business, the reserves for which prove through analysis to be redundant, with the results of one or more products or lines of business, the reserves for which prove through analysis to be deficient. The appointed actuary must be satisfied that the asset adequacy results for the various products or lines of business for which the results are so aggregated:

(i) Are developed using consistent economic scenarios;

or

(ii) Are subject to mutually independent risks, i.e., the likelihood of events impacting the adequacy of the assets supporting the redundant reserves is completely unrelated to the likelihood of events impacting the adequacy of the assets supporting the deficient reserves.

(c) In the event of any aggregation, the actuary must disclose that in his or her opinion such reserves were aggregated on the basis of method (a), (b)(i), or (b)(ii) of this subsection, whichever is applicable, and describe the aggregation in the supporting memorandum.

(2) Selection of assets for analysis: The appointed actuary shall analyze only those assets held in support of the reserves which are the subject for specific analysis, hereafter called "specified reserves." A particular asset or portion thereof supporting a group of specified reserves cannot support any other group of specified reserves. An asset may be allocated over several groups of specified reserves. The annual statement value of the assets held in support of the reserves shall not exceed the annual statement value of the specified reserves, except as provided in subsection (3) of this section. If the method of asset allocation is not consis-

tent from year to year, the extent of its inconsistency should be described in the supporting memorandum.

(3) Use of assets supporting the interest maintenance reserve and the asset valuation reserve:

(i) An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, must be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

(ii) The amount of the assets used for the AVR shall be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum.

(iii) The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

(4) Required interest scenarios:

(a) For the purpose of performing the asset adequacy analysis required by this regulation, the qualified actuary shall follow standards adopted by the Actuarial Standards Board or equivalent standards approved in advance by the commissioner. In the analysis, the appointed actuary shall consider the effect of at least the following interest rate scenarios:

(i) Level with no deviation;

(ii) Uniformly increasing over ten years at a half percent per year and then level;

(iii) Uniformly increasing at one percent per year over five years and then uniformly decreasing at one percent per year to the original level at the end of ten years and then level;

(iv) An immediate increase of three percent and then level;

(v) Uniformly decreasing over ten years at a half percent per year and then level;

(vi) Uniformly decreasing at one percent per year over five years and then uniformly increasing at one percent per year to the original level at the end of ten years and then level; and

(vii) An immediate decrease of three percent and then level.

(b) For all scenarios used, projected interest rates for a five-year treasury note need not be reduced beyond the point where the five-year treasury note yield would be at fifty percent of its initial level.

(c) The beginning interest rates may be based on interest rates for new investments as of the valuation date similar to recent investments allocated to support the product being tested or be based on an outside index, such as treasury yields, of assets of the appropriate length on a date close to the valuation date.

(d) The method used to determine the beginning yield curve and associated interest rates shall be specifically defined. The beginning yield curve and associated interest rates shall be consistent for all interest rate scenarios.

(5) Documentation: The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed,

the analyses performed, the bases for assumptions, and the results obtained.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-400, filed 12/30/94, effective 1/30/95.]

Chapter 284-10 WAC

SHORT-TERM HEALTH INSURANCE REFORM

WAC

284-10-010	Purpose, intent, and authority.
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WAC 284-10-010 Purpose, intent, and authority.

The purpose of this chapter is to effectuate the short-term health insurance reforms enacted as part of the Health Care Reform Act (sections 280 through 291, chapter 492, Laws of 1993). These rules are intended to improve individual and group access to needed health care benefits during the transition to a fully reformed health services system by limiting the use of preexisting condition limitations and exclusions; and by requiring guaranteed renewability of health plans.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-010, filed 4/1/94, effective 5/2/94.]

WAC 284-10-015 Scope and applicability. The rules contained in this chapter shall apply to all health carriers and all health plans, as defined in this chapter, as follows:

(1) WAC 284-10-030 (portability) shall apply to all carriers' individual and group health plans issued or renewed on or after January 1, 1994 and to all individual and group health plans currently in-force as to the addition of new persons to such plans on or after January 1, 1994.

(2) WAC 284-10-060 (guaranteed renewability) shall apply to all carriers' individual and group health plans issued or renewed on or after July 1, 1994.

(3) WAC 284-10-050 (preexisting condition limitations) shall apply to all carriers' individual and group health plans issued or renewed on or after July 1, 1994 and shall apply to all individual and group health plans in-force on or after July 1, 1994 to the extent such health plans contain provisions in conflict with WAC 284-10-050.

(4) For purposes of determining which types of coverage an individual or group may move from and be able to receive the benefits of portability under this chapter, "health plan" or "plan" includes all plans as defined in WAC 284-10-020.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-015, filed 4/1/94, effective 5/2/94.]

WAC 284-10-020 Definitions. Unless otherwise specifically provided, the definitions contained in this section apply throughout this chapter.

"Health carrier" or "carrier" means a disability insurer, health care service contractor, or health maintenance organization authorized to do business in this state.

"Health plan," or "plan" means any individual or group: Policy, agreement, or other contract providing coverage for medical, surgical, hospital, or emergency care services. "Health plan" or "plan" does not mean or include: Hospital confinement indemnity coverage as described in WAC 284-50-345; disability income protection coverage as described in WAC 284-50-355; accident only coverage as described in WAC 284-50-360; specified disease and specified accident coverage as described in WAC 284-50-365; limited benefit health insurance coverage as described in WAC 284-50-370; long-term care benefits as described in chapter 48.84 RCW; Medicare supplemental health insurance as described in chapter 48.66 RCW; fully self-insured coverage governed by the federal Employee Retirement Income Security Act; or limited health care coverage such as dental only, vision only, or chiropractic only.

"Covered person" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan as described in WAC 284-10-015.

"Preexisting condition" means any medical condition, illness, or injury that existed at any time prior to the effective date of coverage.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-020, filed 4/1/94, effective 5/2/94.]

WAC 284-10-030 Portability of health insurance benefits. (1) In addition to the requirements of WAC 284-10-050, every health carrier shall waive any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different health plan at any time during the three-month period immediately preceding the date of application for the new health plan to the extent that such person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least twelve months under the immediately preceding health plan, the carrier may not impose a waiting period for coverage of preexisting conditions unless the plan is dissimilar to the immediately preceding plan as determined in accordance with subsection (4) of this section. If the person was continuously covered for less than twelve months under the immediately preceding health plan, the carrier may not impose a waiting period for a preexisting condition that exceeds the difference between the number of months the person was continuously covered under the immediately preceding health plan and any preexisting condition waiting period under the new health plan. For example:

If both the preceding and new plans impose a waiting period of six months for preexisting conditions and the covered person satisfied three months of the preceding six-month waiting period, the new health plan may not impose a waiting period for preexisting conditions longer than three months.

(2) A health carrier may not avoid the portability requirements of this section by denying an application for a new health plan based upon health conditions that were covered under the immediately preceding health plan. If the person applies for a health plan within the three-month period immediately following the termination of coverage under the immediately preceding health plan, the carrier shall issue a health plan irrespective of the health status of the person seeking coverage except for those health conditions excluded under the immediately preceding health plan. However, if a health condition was subject to a rider or other contractual limitation under the preceding health plan that excluded, limited, or reduced coverage or benefits for an individual's specifically named or described condition, the new plan shall credit the period satisfied by the covered person under the preceding plan so that such rider or other contractual limitation may be cancelled in accordance with the procedures described in RCW 48.20.510, 48.21.290, 48.44.430 and 48.46.500 or other rules as applicable.

A health carrier covering a group may not refuse to extend group coverage or exclude coverage for health conditions covered under an immediately preceding group or individual health plan for a person newly eligible for coverage under an existing group health plan.

When an employer providing group health coverage to his or her employees imposes a probationary period or similar delay in eligibility for health plan coverage of new employees, the health carrier shall count the day of first employment with the new employer as the first day of coverage for purposes of applying the portability of benefit provisions of this section so that the new employees and dependents obtain the protections of this rule at the end of such probationary period.

(3) A carrier may not avoid the portability requirements of this section by taking into consideration, for rating purposes, the health condition or health experience of a person applying for an individual health plan or of a person being added to an existing group plan. For example, a person being added to a group or applying for an individual health plan who is availing himself or herself of the portability provisions of this section may not be rated based upon health conditions or past health experience. However, a group switching to another carrier is not subject to this subsection's restriction on the use of health conditions or past health experience for rating purposes. The new group carrier must comply with other provisions of this chapter but remains free to rate the new group in accordance with approved rating practices.

(4) For purposes of this section only, a new health plan is similar to the immediately preceding health plan if the actuarial value of the benefits under the new health plan as a whole is not more than twenty-five percent greater than the benefits provided under the immediately preceding health plan when all cost-sharing and other benefit limitations are taken into consideration.

A health carrier asserting that the new health plan is dissimilar to the immediately preceding health plan of a person applying for coverage must provide such person with a written statement describing the basis for the carrier's determination.

(5) Nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its

existing health plans. For example, if a person was provided maternity benefits under the immediately preceding health plan, the carrier need not amend the new health plan being purchased to provide such benefits if the new health plan being purchased does not include maternity benefits for any covered person. In addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history. For example, this rule does not include maternity benefits for any covered person. In addition, not apply to a one year waiting period for use of a particular benefit (e.g. organ transplants) imposed equally upon all covered persons without regard to health condition.

(6) Carriers who have filed a certification with the commissioner, withdrawing from the market as provided in WAC 284-10-070 of this chapter, must comply with the portability of benefits provisions of this section as such provisions relate to an individual being added to an existing group or individual health plan. While a carrier withdrawing from the market need not write new group business, such carrier, in servicing existing health plans, must allow new employees or other beneficiaries of the group or individual plan to be added to the plan consistent with the provisions of this section.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-030, filed 4/1/94, effective 5/2/94.]

WAC 284-10-050 Restrictions on the denial, exclusion, or limitation of health benefits for preexisting conditions. (1) Whenever there is a conflict between this section and other sections of this chapter, the provisions of this section governing the denial, exclusion, and limitation of coverage for preexisting conditions supersede other provisions of this chapter governing the same or similar subject matter. For purposes of this section "preexisting condition" means any health condition, illness, or injury which existed at any time prior to the effective date of health plan coverage.

(2) Notwithstanding other provisions of this chapter or Title 284 of the Washington Administrative Code, for the period beginning July 1, 1994 and continuing until October 1, 1994, no carrier offering health plans may reject any individual based on the person's preexisting condition or exclude or otherwise limit coverage for a covered person's preexisting conditions as defined in this section.

For example, if the covered person needs a heart transplant and the plan provides coverage for heart transplants, the carrier may not do any of the following: Deny or exclude coverage for heart transplants as to this particular covered person because the covered person has a preexisting condition; impose any preexisting condition waiting period before providing coverage for the heart condition; or deny coverage altogether for that individual. In addition, a carrier may not condition issuance of a group plan upon the exclusion of an individual within the group nor may a carrier issue a separate plan to an individual within the group to avoid inclusion of the individual under the group plan. However, nothing contained in this section shall be deemed to require a carrier to provide benefits not ordinarily available under the plan. For example, if the covered person

needs a heart transplant and the plan does not cover heart transplants, the carrier has not improperly denied coverage for a preexisting condition. This rule does not prohibit a carrier from imposing waiting periods or other limitations with respect to particular medical procedures or treatments for all persons covered by the plan; rather, the rule prohibits an insurer from imposing waiting periods, riders, or other restrictions on the basis of the health status of a specific individual.

(3) After October 1, 1994, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage or for which a prudent person would have sought advice from a health care provider. For example, if an individual were treated for a heart condition in the three-month period before the effective date of coverage under a policy, the carrier could impose a three-month waiting period before providing any type of coverage for the heart condition. To the extent that preexisting condition waiting periods continue after October 1, 1994, carriers must comply with provisions of WAC 284-10-030(1) that require a carrier to credit preexisting condition waiting periods for persons who had similar coverage under a different plan.

On and after July 1, 1994, no carrier may enforce a plan provision that conflicts with the provisions of this section. For example, if a covered person purchased coverage on April 1, 1994 and the plan contained a twelve month waiting period, that waiting period could not be enforced after July 1, 1994 because enforcement of the waiting period would conflict with the provisions of this section. By way of additional example, if a covered person purchased coverage on March 1, 1994 and the plan contained an exclusion for that individual for problems related to asthma, the exclusion could not be enforced by the carrier after July 1, 1994 and coverage would have to be extended for asthma.

(4) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals or groups who are higher than average health risks. For example, a carrier could not create a new rate classification for "uninsurable risks."

[Statutory Authority: RCW 48.01.200, 48.02.060, 48.20.540, 48.21.340 and 48.46.550. 94-13-216 (Order R 94-13), § 284-10-050, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 48.01.200, 48.02.060, 48.20.540, 48.21.340, 48.44.480 and 48.46.550. 94-08-081 (Order R 94-6), § 284-10-050, filed 4/5/94, effective 5/6/94.]

WAC 284-10-060 Guaranteed renewability—Health insurance. Purpose, intent, and authority. (1) Except as provided in subsection (5) of this section, all health plans issued or renewed on or after July 1, 1994, shall contain or incorporate by endorsement, a guarantee of the continuity of coverage of the plan.

(2) For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date after June 30, 1994, upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. In the case of group plans, the carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from cancelling or nonrenewing a health plan, without the prior approval of the insurance commissioner for:

- (a) Nonpayment of premium;
- (b) Violation of published policies of the carrier that have been approved by the insurance commissioner;
- (c) Covered persons entitled to become eligible for Medicare benefits who fail to apply for a Medicare supplement plan or Medicare Cost, Risk, or HCPP plan offered by the carrier pursuant to federal laws and regulations;
- (d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;
- (e) Covered persons committing fraudulent acts as to the carrier;
- (f) Covered persons who materially breach the health plan or
- (g) Change or implementation of federal or state health care reform laws that no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage of health plans shall not prevent a carrier from cancelling or nonrenewing a health plan, with the prior written approval of the insurance commissioner, because of a change in the covered person's physical or mental condition or health.

(b) The insurance commissioner may approve the cancellation or nonrenewal of a health plan because of a change in the covered person's physical or mental condition or health only when the carrier has obtained for the covered person comparable coverage with another carrier.

(5) The provisions of this section do not apply to health plans deemed by the commissioner to be for a unique, limited or short-term purpose after a written request for such classification by the carrier and subsequent written approval by the commissioner.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-060, filed 4/1/94, effective 5/2/94.]

WAC 284-10-070 Certification of withdrawal from the market and exemption from short-term reform rules. Except as otherwise provided by title 48 RCW and WAC 284-10-030 a carrier filing the certification contained in this section may continue to service existing carrier health plans in force or renewed in this state without complying with the provisions of this chapter.

STATE OF WASHINGTON
CERTIFICATION
Withdrawal from Insurance Market

Company Name: _____
Form number(s) and generic description of form(s) to which this certification applies: _____

"I hereby certify that effective January 31, 1994 (company name) will write no new individual or group health plans for persons in Washington state and that (company name) has no present intention of becoming certified as a certified health plan or of offering a uniform benefit plan as described and governed by chapter 43.72 RCW."

I confirm that all covered persons shall be notified of our decision to stop accepting new business and of our intention to nonrenew all health plans in Washington state whenever chapter 43.72 RCW (Washington state health care reform law) prohibits the continuation or sale of forms inconsistent with Washington state health care reform laws.

I confirm that existing group health plans will be notified that (company name) will comply with the portability of benefit provisions of WAC 284-10-030 as to the addition of covered persons to the group."

Chief Executive Officer

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-070, filed 4/1/94, effective 5/2/94.]

WAC 284-10-090 Severability provision. If any section or portion of a section of this chapter, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Statutory Authority: RCW 48.01.200, 48.01.030, 48.02.060 (3)(a), 48.20.540, 48.21.340, 48.30.300, 48.44.480, 48.44.490, 48.46.550 and 48.46.560. 94-08-060 (Order R 94-7), § 284-10-090, filed 4/1/94, effective 5/2/94.]

**Chapter 284-12 WAC
AGENTS, BROKERS AND ADJUSTERS**

WAC

- 284-12-080 Requirements for separate accounts.
- 284-12-090 When general agent may accept applications from nonappointed agents.
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MANAGING GENERAL AGENTS

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DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

284-12-010	Qualifications of agents of insurers authorized to transact more than one kind of insurance—Exceptions. [Order R 76-6, § 284-12-010, filed 11/10/76; Rule dated 5/1/54, filed 3/22/60.] Repealed by 90-04-060 (Order R 90-1), filed 2/2/90, effective 3/5/90. Statutory Authority: RCW 48.02.060.
284-12-024	Waiver of unauthorized alien insurers' financial requirements. [Statutory Authority: RCW 48.02.060. 80-06-039 (Order R-80-6), § 284-12-024, filed 5/12/80.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-025	Brokers—Surplus line—Qualifications and examination. [Rule dated 1/20/58, filed 3/22/60.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-026	Surplus line brokers—Must file power of attorney for the service of process. [Rule dated 8/2/54, filed 3/22/60.] Repealed by 79-11-079 (Order R 79-5), filed 10/22/79. Statutory Authority: RCW 48.02.060.
284-12-027	Form for surplus line insurer to designate person to receive legal process. [Statutory Authority: RCW 48.02.060. 79-11-079 (Order R 79-5), § 284-12-027, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-028	Surplus line brokers' form to be filed; contract stamp to be used. [Statutory Authority: RCW 48.02.060. 79-11-079 (Order R 79-5), § 284-12-028, filed 10/22/79.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
284-12-030	Nonresident agent, broker, or adjuster's license. [Rule dated 11/4/57, filed 3/22/60.] Repealed by 90-04-060 (Order R 90-1), filed 2/2/90, effective 3/5/90. Statutory Authority: RCW 48.02.060.
284-12-040	Adjusters' licenses, RCW 48.14.010, 48.17.050, 48.17.060, 48.17.070, 48.17.110, 48.17.120 and 48.17.380. [Rule dated 11/15/55, filed 3/22/60.] Repealed by 90-04-060 (Order R 90-1), filed 2/2/90, effective 3/5/90. Statutory Authority: RCW 48.02.060.
284-12-100	Twisting. [Rule filed 12/1/61, effective 12/1/61.] Repealed by Order R-68-1 (part), filed 4/23/68, effective 10/1/68.

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 (6) 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) Disbursements or withdrawals from a separate account shall be made for the following purposes only, and in the manner stated:

(a) For charges imposed by a bank or other financial institution for operation of the separate account;

(b) For payments of premiums, directly to insurers or other producers entitled thereto;

(c) For payments of return premiums, directly to the insureds or other persons entitled thereto;

(d) For payments of commissions and other funds belonging to the separate account's producer, directly to another account maintained by such producer as an operating or business account; and

(e) For transfer of fiduciary funds, directly to another separate premium account which meets the requirements of this section.

(5)(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.

(6)(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.

(7) 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.

(8) 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.

(9) 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.

(10)(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.

(c) Funds received by an agent who is employed by and offices with another agent may be deposited into and accounted for through the separate account of the employing agent. This provision does not, however, authorize the agent-employee to represent an insurer as to which he or she has no appointment.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.17.480 and 48.17.600, 90-04-042 (Order R 90-2), § 284-12-080, filed 1/31/90, effective 3/3/90. 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 284-12-090 When general agent may accept applications from nonappointed agents. (1) If so empowered, in writing, by an authorized insurer, its general agent licensed pursuant to RCW 48.05.310 may accept applications for insurance from licensed agents who are not appointed by such insurer but who are licensed for the kind of insurance involved, where the risk involved is placed in a nonstandard or specialty market of such insurer. Nothing in this section restricts the right of brokers to submit applications to general agents.

(2) A nonstandard or specialty market is one for other than life or disability insurance which provides coverage for risks which are not ordinarily insured by a majority of insurers authorized to write such risks and which are of such type that an agent licensed for the kind of insurance involved will have such infrequent demands to obtain the coverage that appointment of the agent to represent the insurer is not justified.

(3) Before accepting an application from a nonappointed agent, the general agent shall furnish the nonappointed agent with written instructions setting forth the agent's authority, emphasizing the limited nature thereof, and specifically stating that the agent has no authority to bind an insurance risk on behalf of the insurer for which the general agent is acting. The instructions shall set forth the procedures to be followed by the agent, and identify the nonstandard or specialty business as to which the agent may take applications, the application forms which are to be used, and the material which may be used to write the business, which may include underwriting criteria and rates. The instructions shall be signed by the general agent and the nonappointed agent shall sign the instructions to acknowledge their receipt and acceptance. Both the general agent and nonappointed agent shall retain copies of such instructions and make copies available to the commissioner upon request.

(4)(a) Unless otherwise instructed by the general agent, in writing, the nonappointed agent shall submit only an applicant's check, draft, or money order endorsed or payable to the insurer or its general agent, in payment of premium,

and shall forward it with the application to the general agent. If the general agent permits the nonappointed agent to receive cash or other payment of premium from the applicant, it shall be deposited in a separate premium account of the nonappointed agent, and be maintained and disbursed, in the same manner as with other premiums received by the agent.

(b) The nonappointed agent shall promptly provide a receipt to the applicant for any payment received which shall be dated, identify the agent and the agent's address, identify the person by or for whom payment is made, state the amount received, identify the applicable insurer by its full legal name, identify the coverage for which application is made, include or be accompanied with a disclaimer of binding authority, and briefly explain that an application for insurance is being made by the agent to the general agent (who shall be identified) to assist the applicant or prospective insured to obtain insurance coverage. The receipt need not be an independent document. The information required in the receipt may be incorporated in an application and serve in lieu of a separate receipt, if a copy of such application is given to the applicant or prospective insured when payment is received by the nonappointed agent.

(5) By permitting its general agent to accept business from a nonappointed agent pursuant to RCW 48.05.310 and this section, the nonappointed agent becomes the representative of the insurer to the extent that the services of the nonappointed agent are utilized in the transaction of insurance for which application is made or is to be made to the insurer. In accord therewith, it is the intent of this subsection that:

(a) The insurer will be deemed to have received any premiums paid by the applicant or insured to the nonappointed agent.

(b) Return premiums or claim payments delivered by the insurer or general agent to the nonappointed agent shall not be deemed to have been paid to the insured or claimant until such payments are received by the insured or claimant.

(6) Such business as is permitted by this section shall not be bound by the nonappointed agent. The application shall have printed thereon or have attached thereto a prominent notice advising the applicant that the agent has no authority to bind coverage and shall include a statement informing the applicant as to when and how the coverage applied for will be bound. Applicants shall sign or initial such notice to indicate that it has been brought to their attention, and shall be given a copy of such application with such notice. The name, address, and telephone number of the general agent shall be set forth in the application.

(7) Except as provided in subsection (8) of this section, a nonappointed agent's activities with respect to the insurance obtained under this section shall be limited to its procurement through the submission of the application as herein provided. When coverage is bound, the insured shall be notified by the insurer or its general agent of the person or entity with whom the insured should deal relative to future transactions, such as requesting policy changes, paying premiums, renewing the policy, or reporting claims.

(8) If the insurer elects to utilize the services of the nonappointed agent relative to transactions pertaining to the policy which occur after its procurement, including receipt of premiums from the insured, its general agent may file

notice with the commissioner that the nonappointed agent is granted a limited appointment permitting such agent to act on behalf of the insurer with respect to insurance placed through the general agent pursuant to RCW 48.05.310(3) and this section.

(a) Such notice shall identify the insurer, the general agent, and the agent, including the agent's "PIC code" license identification number used by the commissioner, and specifically state that such agent is authorized to act for the insurer with respect to nonstandard or specialty insurance placed through the general agent pursuant to RCW 48.05.310 and this section.

(b) Such limited appointment or authorization shall continue in force, dependent upon the agent continuing to have an agent's license for the kind of insurance involved, until the commissioner receives written notice from the insurer, the general agent or the nonappointed agent that it is terminated.

(c) Under current statutes, the cost for filing the notice with respect to each nonappointed agent will be a one-time fee of five dollars. Upon receipt of the filing, the commissioner will enter the information into the licensing records pertaining to the agent and the general agent. It is anticipated that a list of the nonappointed agents having limited authorization to represent an insurer will be sent to the appropriate general agent biennially to assist in maintaining an accurate and current list.

(d) It is the responsibility of the insurer and its general agent to keep insureds informed in a timely manner with respect to the persons authorized to act on behalf of the insurer. A nonappointed agent, with or without the limited authority permitted by this section, shall not be considered a broker or representative of the insured. By using such agent, the insurer accepts, as a general rule, that the agent's acts are those of the insurer and that the knowledge such agent obtains is imputed to the insurer. A notice relative to the insurance given to such agent is not notice to the insured.

(9) Records of each transaction resulting from the operation of this section shall be maintained by the nonappointed agent and by the general agent, and shall specifically include all of the following:

(a) Identification of the insured or prospective insured, insurer, general agent, and nonappointed agent, whether or not insurance is actually procured, and including, in the case of the nonappointed agent's records, identity of any applicant or prospective insured who pays premium to such agent in expectation of obtaining insurance from an insurer which has not appointed the agent, whether or not an application is submitted.

(b) A brief description of the subject of the insurance, the policy number, date coverage commences, and the amount of premium paid or to be paid.

(c) Copies of the documents utilized by the licensee in each transaction.

(10) For purposes of this section an "insurance transaction" or the "transaction of insurance" or "transacting insurance," or similar forms of those words includes any:

(a) Solicitation.

(b) Negotiations preliminary to execution.

(c) Execution of an insurance contract.

(d) Transaction of matters subsequent to execution of the contract and arising out of it.

(e) Insuring.

(11) A failure to comply with this section shall be an unfair or deceptive act or practice and an unfair method of competition in the conduct of the business of insurance, pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.05.140 and 48.17.530.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010 and 48.17.500(3). 94-14-110 (Order R 94-14), § 284-12-090, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060, 48.05.310, 48.30.010 and 48.15.080. 91-23-032 (Order R 91-7), § 284-12-090, filed 11/13/91, effective 1/1/92.]

WAC 284-12-095 Unfair practice with respect to use of general agent defined. It is an unfair or deceptive practice and an unfair method of competition pursuant to RCW 48.30.010 for an authorized insurer to cancel or refuse to renew any insurance policy because its contract or arrangement with a general agent or a nonappointed agent through whom such policy was written has been terminated.

[Statutory Authority: RCW 48.02.060, 48.05.310, 48.30.010 and 48.15.080. 91-23-032 (Order R 91-7), § 284-12-095, filed 11/13/91, effective 1/1/92.]

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.]

MANAGING GENERAL AGENTS

WAC 284-12-200 Operating in this state. A managing general agent is "operating in this state" for purposes of the Managing General Agents Act (chapter 48.— RCW, sections 34-42, chapter 462, Laws of 1993) ("the act") section 38(5), chapter 462, Laws of 1993, if he or she does in Washington any act for which a license is required by the act or chapter 48.17, or does in Washington any activities listed in section 35 (3)(a)(i) or (ii), chapter 462, Laws of 1993.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-200, filed 9/1/93, effective 10/2/93.]

WAC 284-12-210 Affiliates. "Affiliates" as used in section 35 (3)(a), chapter 462, Laws of 1993, has the meaning indicated in RCW 48.—, section 2, chapter 462, Laws of 1993.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-210, filed 9/1/93, effective 10/2/93.]

WAC 284-12-220 Licensed in this state. A person is licensed in this state for purposes of section 36 (1) and (2), chapter 462, Laws of 1993, if he or she holds a resident or nonresident agent's license issued by the commissioner.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-220, filed 9/1/93, effective 10/2/93.]

WAC 284-12-230 Notification of appointment. When notifying the commissioner of the appointment of a managing general agent under section 38(5), chapter 462, Laws of 1993, in addition to the information specified there, the insurer shall include the following information about the appointee:

- (1) Current address;
- (2) Other addresses in the past five years;
- (3) What licenses are held, and which states issued them;
- (4) Whether any license has ever been revoked, suspended, or not renewed, and whether any disciplinary action has ever been taken or is now being considered by an insurance regulatory official or officer, and if so, give details.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-230, filed 9/1/93, effective 10/2/93.]

WAC 284-12-250 Employee. Whether a person is an "employee" of the insurer for purposes of section 35 (3)(b)(i), chapter 462, Laws of 1993, depends on the facts and is not controlled by a mere labelling of the person as an employee in an agreement.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-250, filed 9/1/93, effective 10/2/93.]

WAC 284-12-260 Form of financial statements. The independent audited financial statements required by section 38(1), chapter 462, Laws of 1993, shall be in such a form that they clearly show the results of operations, and the assets, liabilities, and equity of the managing general agent, and the income and expense attributable to acting as managing general agent for the insurer. Nothing in the act or this regulation (WAC 284-12-200 through 284-12-260) prevents the insurer from requiring additional information, more detail, or a specified format so long as that specified format at least meets the requirements of this section.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-260, filed 9/1/93, effective 10/2/93.]

WAC 284-12-270 Expiration and renewal of appointments. Appointments of managing general agents shall be for two years. They expire unless timely renewed. They expire on the same date that agent appointments for the same insurer expire under WAC 284-17-410.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010 and 48.17.500(3). 94-14-110 (Order R 94-14), § 284-12-270, filed 7/6/94, effective 8/6/94. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-270, filed 9/1/93, effective 10/2/93.]

WAC 284-12-280 Claim thresholds. The claim threshold under sections 35 (3)(a)(i) and 37 (7)(b)(i) and (v), chapter 462, Laws of 1993, is twenty thousand dollars.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 41. 93-19-009 (Order R 93-13), § 284-12-280, filed 9/1/93, effective 10/2/93.]

Chapter 284-13 WAC
ASSETS—LIABILITIES—INVESTMENTS AND
REINSURANCE

WAC

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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.]

EARNED SURPLUS

WAC 284-13-160 Definition of "earned surplus."

(1) As used in RCW 48.08.030(1), "earned surplus" means that part of surplus that represents net earnings, gains, or profits, after deduction of all losses, that have not been distributed to share holders as dividends or transferred to stated capital or capital surplus or lawfully applied to other purposes. It does not include unrealized appreciation of assets, unrealized capital gains, or reevaluation of assets.

(2) Earned surplus can be determined from the annual statement. On the 1992 convention blank, (a) for stock life companies, earned surplus is Unassigned Funds (page 3, line 34) less any unrealized gains included in that figure; and (b) for property and casualty stock companies, earned surplus is Unassigned Funds (page 3, line 25B), less any unrealized gains included in that figure. On convention blanks for other years, the determination is adjusted to allow for changes in the form.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400, 93-19-004 (Order R 93-8), § 284-13-160, filed 9/1/93, effective 10/2/93.]

ASSETS

WAC 284-13-210 Valuation of bonds. All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer may, if amply secured and not in default as to principal or interest, be valued as follows:

(1) If purchased at par, at the par value.

(2) If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of such method, according to such accepted method of valuation as is approved by the commissioner.

(3) Purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage, or express charges paid in the acquisition of such bonds or other evidences of debt.

(4) No method of valuation shall be inconsistent with any applicable valuation or method used by insurers in general, or any such method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

[Statutory Authority: RCW 48.02.060, 48.12.180, 48.12.190 and 48.12.200, 93-19-007 (Order R 93-11), § 284-13-210, filed 9/1/93, effective 10/2/93.]

WAC 284-13-220 Valuation of other securities. (1) Securities, other than those referred to in WAC 284-13-210, held by an insurer shall be valued, in the discretion of the commissioner, at their market value, or at their appraised value, or at prices determined by the commissioner as representing their fair market value.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the commissioner and in accordance with such method of valuation as he or she may approve.

(3) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which would be eligible under chapter 48.13 RCW for investment of the funds of the insurer directly.

(4) No valuations under this section shall be inconsistent with any applicable valuation or method then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

[Statutory Authority: RCW 48.02.060, 48.12.180, 48.12.190 and 48.12.200, 93-19-007 (Order R 93-11), § 284-13-220, filed 9/1/93, effective 10/2/93.]

WAC 284-13-280 Real estate appraisals. (1) Except as provided in subsection (2) of this section, for purposes of RCW 48.13.120(1) and 48.13.140, an insurer may rely on an appraisal that is less than one year old.

(2) An insurer may not rely on an appraisal if the insurer knows or should know that the appraisal is not reliable. An appraisal may be "not reliable" because it was incorrect when done, because conditions affecting the property have changed, or for other reasons.

[Statutory Authority: RCW 48.02.060. 93-19-010 (Order R 93-14), § 284-13-280, filed 9/1/93, effective 10/2/93.]

RISK-BASED CAPITAL FOR LIFE AND DISABILITY INSURERS

WAC 284-13-310 Definitions. As used in this rule, these terms shall have the following meanings:

"Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with WAC 284-13-320(3).

"Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

"Domestic insurer" means any life or disability insurance company formed under the laws of this state.

"Foreign or alien insurer" means any life or disability insurance company which is authorized to do business in this state under chapter 48.05 RCW but is not domiciled in this state.

"NAIC" means the National Association of Insurance Commissioners.

"Negative trend" means a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions defined in this section.

"RBC" means risk-based capital.

"RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"RBC level" means an insurer's company action level RBC; regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

"Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

"Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

"Mandatory control level RBC" means the product of .70 and the authorized control level RBC;

"Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

"RBC plan" means a comprehensive financial plan containing the elements specified in WAC 284-13-330(2). If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

"RBC report" means the report required in WAC 284-13-320.

"Total adjusted capital" means the sum of:

An insurer's statutory capital and surplus; and
Such other items, if any, as the RBC instructions may provide.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-310, filed 9/1/93, effective 10/2/93.]

WAC 284-13-320 RBC reports. (1) Every domestic insurer shall, on or prior to each March 15 (the "filing date"), prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) Fifteen days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) An insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account (and may adjust for the covariance between):

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions; determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) If a domestic insurer files an RBC report which in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-320, filed 9/1/93, effective 10/2/93.]

WAC 284-13-330 Company action level event. (1) "Company action level event" means any of the following events:

(a) The filing of an RBC report by an insurer which indicates that:

(i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) The insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and has a negative trend;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in (a)(i) or (ii) of this subsection (provided the insurer does not challenge the adjusted RBC report under WAC 284-13-370); or

(c) If the insurer challenges an adjusted RBC report that indicates the event in (a)(i) or (ii) of this subsection under WAC 284-13-370, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner a comprehensive financial plan which shall:

(a) Identify the conditions in the insurer which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory financial position, results of operations, changes in cash flows, and significant statutory accounting policies. (The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense, and benefit component);

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

(3) The RBC plan shall be submitted:

(a) Within forty-five days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report pursuant to WAC 284-13-370, within forty-five days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within sixty days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five days after the notification from the commissioner; or

(b) If the insurer challenges the notification from the commissioner under WAC 284-13-370, within forty-five days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under WAC 284-13-370, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) Such state has an RBC provision substantially similar to WAC 284-13-380(1); and

(b) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-330, filed 9/1/93, effective 10/2/93.]

WAC 284-13-340 Regulatory action level event. (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) The notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under WAC 284-13-370;

(c) If the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection under WAC 284-13-370, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within ten days after the filing date;

(e) The failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in WAC 284-13-330(3);

(f) Notification by the commissioner to the insurer that:

(i) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under WAC 284-13-370;

(g) If the insurer challenges a determination by the commissioner under (f) of this subsection pursuant to WAC 284-13-370, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge;

(h) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised

RBC plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under WAC 284-13-370; or

(i) If the insurer challenges a determination by the commissioner under (h) of this subsection pursuant to WAC 284-13-370, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge (unless the failure of the insurer to adhere to its RBC plan or revised RBC plan has no substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event with respect to the insurer).

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required (a "corrective order").

(3) In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five days after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report pursuant to WAC 284-13-370 and the challenge is not in the judgment of the commissioner frivolous, within forty-five days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised RBC plan under WAC 284-13-370, within forty-five days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations of the insurer, and formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-340, filed 9/1/93, effective 10/2/93.]

WAC 284-13-350 Authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater

than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in (a) of this subsection (provided the insurer does not challenge the adjusted RBC report under WAC 284-13-370);

(c) If the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection under WAC 284-13-370, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the insurer has not challenged the corrective order under WAC 284-13-370); or

(e) If the insurer has challenged a corrective order under WAC 284-13-370 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) The commissioner shall take such actions as are required under WAC 284-13-340 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) The commissioner's review of the RBC report, preparation of an adjusted RBC report if any, and consideration of any corrective order and any challenge to a corrective order constitute an examination for purposes of RCW 48.31.030(5). If the commissioner then finds the insurer to be in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to its members, subscribers, or stockholders, or to the public, and if the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, then the commissioner shall take such actions as are necessary to cause the insurer to be placed under regulatory control under chapter 48.31 RCW. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under chapter 48.31 RCW, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in chapter 48.31 RCW. In the event the commissioner takes actions under this subsection (2)(b) pursuant to an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of RCW 48.31.— (section 61, chapter 462, Laws of 1993) pertaining to summary proceedings.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-350, filed 9/1/93, effective 10/2/93.]

WAC 284-13-360 Mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) Notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in (a) of this

subsection, provided the insurer does not challenge the adjusted RBC report under WAC 284-13-370; or

(c) If the insurer challenges an adjusted RBC report that indicates the event in (a) of this subsection under WAC 284-13-370, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) The commissioner's review of the RBC report, preparation of an adjusted RBC report if any, and consideration of any corrective order and any challenge to a corrective order constitute an examination for purposes of RCW 48.31.030(5). The determination that a mandatory control level event has occurred constitutes a finding that the insurer is in such condition that further transaction of business will be hazardous to its policyholders, or to its creditors, or to its members, subscribers, or stockholders, or to the public. Therefore, in the event of a mandatory control level event, the commissioner shall take actions as are necessary to cause the insurer to be placed under regulatory control under chapter 48.31 RCW. In the event the commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of RCW 48.31.— (section 61, chapter 462, Laws of 1993) pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety days after the mandatory control level event if he or she finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-360, filed 9/1/93, effective 10/2/93.]

WAC 284-13-370 Hearings. Upon:

(1) Notification to an insurer by the commissioner of an adjusted RBC report; or

(2) Notification to an insurer by the commissioner that:

(a) The insurer's RBC plan or revised RBC plan is unsatisfactory; and

(b) Such notification constitutes a regulatory action level event with respect to such insurer; or

(3) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(4) Notification to an insurer by the commissioner of a corrective order with respect to the insurer, the insurer shall have the right to a hearing, in accordance with chapters 48.04 and 34.05 RCW. The insurer shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under subsection (1), (2), (3), or (4) of this section.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-370, filed 9/1/93, effective 10/2/93.]

WAC 284-13-380 Confidentiality and prohibition on announcements. (1) All RBC reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC plans (including the results or report of any examination or analy-

sis of an insurer performed pursuant hereto and any corrective order issued by the commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to any provision of the insurance laws of this state.

(2) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required, under the provisions of this rule, the making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and an unfair method of competition and an unfair and deceptive practice and is therefore prohibited. If, however, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels (or any of them) or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-380, filed 9/1/93, effective 10/2/93.]

WAC 284-13-390 Supplemental provisions. The provisions of this rule are supplemental to any other provisions of the laws and rules of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws and rules including, but not limited to, chapter 48.31 RCW and WAC 284-16-300 through 284-16-320.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-390, filed 9/1/93, effective 10/2/93.]

WAC 284-13-400 Foreign and alien insurers. (1) Any foreign or alien insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended the later of:

(a) The date an RBC report would be required to be filed by a domestic insurer under this rule; or

(b) Fifteen days after the request is received by the foreign or alien insurer.

Any foreign or alien insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event or regulatory action level event with respect to any foreign or alien insurer as determined under the RBC statute or rule applicable in the state of domicile of the insurer (or, if no RBC provision is in force in that state, under the provisions of this rule), if the insurance commissioner of the state of domicile of the foreign or alien insurer fails to require the foreign or alien insurer to file an RBC plan in the manner specified under the RBC statute or rule (or, if no RBC provision is in force in the state, under WAC 284-13-330), the commissioner may require the foreign or alien insurer to file an RBC plan with the commissioner. In such event, the failure of the foreign or alien insurer to file an RBC plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(3) The commissioner's review of the RBC report, preparation of an adjusted RBC report if any, and consideration of any corrective order and any challenge to a corrective order constitute an examination for purposes of RCW 48.31.030(5). The determination that a mandatory control level event has occurred constitutes a finding that the insurer is in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to its members, subscribers, or stockholders, or to the public. Therefore, in the event of a mandatory control level event with respect to any foreign or alien insurer, if no domiciliary receiver has been appointed with respect to the foreign or alien insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign or alien insurer, the commissioner may make application to the circuit court for Thurston County permitted under chapter 48.31 RCW with respect to the liquidation of property of foreign or alien insurers found in this state, and the occurrence of the mandatory control level event is adequate grounds for the application.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-400, filed 9/1/93, effective 10/2/93.]

WAC 284-13-410 Notices. All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of such notice.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-410, filed 9/1/93, effective 10/2/93.]

WAC 284-13-420 Phase-in provision. For RBC reports required to be filed with respect to 1993, the following requirements shall apply in lieu of the provisions of WAC 284-13-330, 284-13-340, 284-13-350, and 284-13-360:

(1) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(2) In the event of an regulatory action level event under WAC 284-13-340 (1)(a), (b), or (c) the commissioner shall take the actions required under WAC 284-13-330.

(3) In the event of an regulatory action level event under WAC 284-13-340 (1)(d), (e), (f), (g), (h), or (i), or an authorized control level event, the commissioner shall take the actions required under WAC 284-13-340 with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under WAC 284-13-350 with respect to the insurer.

[Statutory Authority: RCW 48.02.060 and 48.05.340(4). 93-19-012 (Order R 93-16), § 284-13-420, filed 9/1/93, effective 10/2/93.]

CREDIT FOR REINSURANCE

WAC 284-13-500 Purpose. The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of RCW 48.12.160. The actions and information required by this regulation are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-500, filed 9/1/93, effective 10/2/93.]

WAC 284-13-510 Credit for reinsurance—Reinsurer holding certificate of authority in this state. Pursuant to RCW 48.12.160, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers that held a certificate of authority to transact that kind of insurance in this state as of the date of the ceding insurer's statutory financial statement.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-510, filed 9/1/93, effective 10/2/93.]

WAC 284-13-520 Credit for reinsurance—Certain reinsurers maintaining trust funds. (1) Pursuant to RCW 48.12.160 (1)(a), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer described in subsection (2) of this section which, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount prescribed below in a qualified United States bank as provided in RCW 48.12.160, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

(2) The trust fund for a group of insurers that includes individual unincorporated underwriters shall consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trustee surplus of which one hundred million dollars shall be held jointly and exclusively for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the commissioner annual certifications by the

group's domiciliary regulator and its independent public accountants of the solvency of each underwriter member of the group.

(3) The trust under RCW 48.12.160 (1)(a) or (b)(i) shall be established in a form approved by the commissioner and complying with that statute and this section. The trust instrument shall provide that:

(a) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty days after entry of the final order of any court of competent jurisdiction in the United States.

(b) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in interest.

(c) The trust shall be subject to examination as determined by the commissioner.

(d) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

(e) No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(f) No amendment to the trust shall be effective unless reviewed and approved in advance by the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-520, filed 9/1/93, effective 10/2/93.]

WAC 284-13-540 Credit for reinsurance ceded to an assuming insurer that does not have a certificate of authority. Pursuant to RCW 48.12.160 (1)(b), the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of RCW 48.12.160 (1)(a) in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds or other assets that are of the types and amounts that are authorized under chapter 48.13 RCW, held subject to withdrawal by and under the control of the ceding insurer, including funds or other such assets held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in RCW 48.12.160 (1)(b)(ii). This security may be in the form of:

(1) Deposits or funds that are assets of the types and amounts that are authorized under chapter 48.13 RCW; or

(2) Clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in RCW 48.12.160 (1)(b)(ii), effective no later than December 31 of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement.

Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs.

An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to this section shall be allowed only when the requirements of WAC 284-13-550 or 284-13-560 are met.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-540, filed 9/1/93, effective 10/2/93.]

WAC 284-13-550 Trust agreements qualified under WAC 284-13-540. (1) As used in this section:

(a) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

(b) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the assuming insurer not holding a certificate of authority for that kind of business.

(c) "Obligations," as used in subsection (3)(k) of this section, means:

(i) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(ii) Reserves for reinsured losses reported and outstanding;

(iii) Reserves for reinsured losses incurred but not reported; and

(iv) Reserves for allocated reinsured loss expenses and unearned premiums.

(2) Required conditions.

(a) The trust agreement shall be entered into between the beneficiary, the grantor, and a trustee which shall be a qualified United States financial institution as defined in RCW 48.12.160 (1)(b).

(b) The trust agreement shall create a trust account into which assets shall be deposited.

(c) All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in (d)(i) of this subsection must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.

(d) The trust agreement shall provide that:

(i) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to

the grantor, subject only to written notice from the beneficiary to the trustee;

(ii) No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(iii) It is not subject to any conditions or qualifications outside of the trust agreement; and

(iv) It shall not contain references to any other agreements or documents except as provided for under (k) of this subsection.

(e) The trust agreement shall be established for the sole benefit of the beneficiary.

(f) The trust agreement shall require the trustee to:

(i) Receive assets and hold all assets in a safe place;

(ii) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(iii) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(iv) Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;

(v) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(vi) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(g) The trust agreement shall provide that at least thirty days, but not more than forty-five days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(h) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established.

(i) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

(j) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct, or lack of good faith.

(k) Notwithstanding other provisions of this regulation, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and disability, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may, notwithstanding any other conditions in this regulation, provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

(i) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(ii) To make payment to the assuming insurer of any amounts held in the trust account that exceed one hundred two percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(iii) Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in RCW 48.12.160(2) apart from its general assets, in trust for such uses and purposes specified in (k)(i) and (ii) of this subsection as may remain executory after such withdrawal and for any period after the termination date.

(l) The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by subsection (4)(a)(ii) of this section, so long as these required conditions are included in the trust agreement.

(3) Permitted conditions.

(a) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety days after receipt by the beneficiary and grantor of the notice, and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(c) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in subsection (4)(a)(ii) of this section.

(d) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be

conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(e) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(4) Additional conditions applicable to reinsurance agreements.

(a) A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

(i) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(ii) Stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of the types permitted by Title 48 RCW or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary, or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and disability, then the trust agreement may contain the provisions described by this paragraph in lieu of including such provisions in the reinsurance agreement;

(iii) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(iv) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(v) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver, or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(A) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(B) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(C) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred (including losses incurred but not reported), loss adjustment expenses, and unearned premium reserves; and

(D) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(b) The reinsurance agreement may also contain provisions that:

(i) Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(A) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(B) After withdrawal and transfer, the market value of the trust account is no less than one hundred two percent of the required amount.

The ceding insurer shall not unreasonably or arbitrarily withhold its approval.

(ii) Provide for:

(A) The return of any amount withdrawn in excess of the actual amounts required for (a)(v)(A), (B), and (C) of this subsection or in the case of (a)(v)(D) of this subsection any amounts that are subsequently determined not to be due; and

(B) Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to (a)(v)(C) of this subsection.

(iii) Permit the award by any arbitration panel or court of competent jurisdiction of:

(A) Interest at a rate different from that provided in (b)(ii)(B) of this subsection;

(B) Court or arbitration costs;

(C) Attorney's fees; and

(D) Any other reasonable expenses.

(c) Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(d) Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to December 31, 1993, will continue to be acceptable until December 30, 1994, at which time the agreements will have to be in full compliance with this regulation for the trust agreement to be acceptable.

(e) The failure of any trust agreement to specifically identify the beneficiary as defined in subsection (1)(a) of this

section shall not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-550, filed 9/1/93, effective 10/2/93.]

WAC 284-13-560 Letters of credit qualified under WAC 284-13-540. (1) The letter of credit must be clean, irrevocable, and unconditional and issued or confirmed by a qualified United States financial institution as defined in RCW 48.12.160 (1)(b)(ii). The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents, or entities, except as provided in subsection (8)(a)(ii)(A) of this section. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).

(2) The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(3) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(4) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than thirty days' notice prior to expiry date or nonrenewal.

(5) The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

(6) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400), then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

(7) The letter of credit shall be issued by a qualified United States financial institution authorized to issue letters of credit, pursuant to RCW 48.12.160 (1)(b)(ii).

(8) Reinsurance agreement provisions.

(a) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions which:

(i) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

(ii) Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(A) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(B) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

(C) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement (such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, and unearned premium reserves); and

(D) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(iii) All of the foregoing provisions of (a) of this subsection should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(b) Nothing contained in (a) of this subsection shall preclude the ceding insurer and assuming insurer from providing for:

(i) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to (a)(ii)(C) of this subsection; and

(ii) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of (a)(ii)(D) of this subsection, any amounts that are subsequently determined not to be due.

(c) When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities, and disability, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of (a)(ii) of this subsection, require that the parties enter into a "trust agreement" which may be incorporated into the reinsurance agreement or be a separate document.

(9) A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-560, filed 9/1/93, effective 10/2/93.]

WAC 284-13-570 Other security. A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-570, filed 9/1/93, effective 10/2/93.]

WAC 284-13-580 Reinsurance contract. Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of this regulation or otherwise in compliance with RCW 48.12.160 after the adoption of this regulation unless the reinsurance agreement:

(1) Includes a proper insolvency clause pursuant to RCW 48.12.160(2); and

(2) Includes a provision whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-580, filed 9/1/93, effective 10/2/93.]

WAC 284-13-590 Contracts affected. All new and renewal reinsurance transactions entered into after December 1, 1993, shall conform to the requirements of this regulation if credit is to be given to the ceding insurer for such reinsurance.

[Statutory Authority: RCW 48.02.060 and 48.12.160. 93-19-002 (Order R 93-6), § 284-13-590, filed 9/1/93, effective 10/2/93.]

REINSURANCE INTERMEDIARIES

WAC 284-13-700 Definitions. (1) Terms used in this regulation (WAC 284-13-700 through 284-13-740) that are defined in the Reinsurance Intermediary Act (chapter 48.—RCW, sections 22 through 33, chapter 462, Laws of 1993) ("the act") have the meaning stated there.

(2) Whether a person is an "employee" of the reinsurer for purposes of section 23 (7)(a), chapter 462, Laws of 1993, depends on the facts and is not controlled by a mere labeling of the person as an employee in an agreement.

(3) A reinsurer is "licensed in this state" for purposes of section 23(8), chapter 462, Laws of 1993, when it holds a certificate of authority to transact the relevant line of insurance.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-700, filed 9/1/93, effective 10/2/93.]

WAC 284-13-710 Applications for license. An application for a license as a reinsurance intermediary by a firm or association may name the members and the designated employees to be authorized to act as reinsurance intermediaries under the license. If those persons are not named on

the application or a supplement to it, then the application must be accompanied by a letter or other document identifying those persons and signed by an officer of the firm or association.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-710, filed 9/1/93, effective 10/2/93.]

WAC 284-13-720 Financial statement of reinsurance intermediary-manager. A reinsurer shall obtain from each reinsurance intermediary-manager, and a reinsurance intermediary-manager shall give to the reinsurer, annual statements of financial condition prepared by an independent certified public accountant. The form of the statements shall be such that the statements clearly show the results of operations, and the assets, liabilities, and equity of the reinsurance intermediary-manager. Nothing in the act or this regulation (WAC 284-13-700 through 284-13-740) prevents a reinsurer from requiring additional information, more detail, or a specified format so long as that specified format at least meets the requirements of this section.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-720, filed 9/1/93, effective 10/2/93.]

WAC 284-13-730 Submission and approval of contracts between reinsurers and reinsurance intermediary—Managers. Contracts filed for approval under section 28, chapter 462, Laws of 1993, must include the provisions required by that section. If those provisions are not in the order given in that section, or if any other provisions precede or separate any of those required provisions, then the submitted contract shall be accompanied by a statement showing where in the contract each required provision is.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-730, filed 9/1/93, effective 10/2/93.]

WAC 284-13-740 Reporting of claims. The reporting threshold under section 28 (9)(b)(v), chapter 462, Laws of 1993, is the lesser of fifty thousand dollars or an amount set by the reinsurer.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 33. 93-19-011 (Order R 93-15), § 284-13-740, filed 9/1/93, effective 10/2/93.]

Chapter 284-14 WAC

REGULATIONS PERTAINING TO FEES AND TAXES

WAC

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

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

(1) Beginning November 15, 1982, the filing fee for filing insurance rates and the filing fee for filing insurance forms shall be fifteen dollars each per filing.

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

(a) A rate filing is a submission at one time from one insurer or rating organization of manuals of classification and manuals of rules and rates, or any modification thereof, and rating schedules or rating plans or a request for a rate

change or deviation for one or more contract forms which may logically be grouped together.

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

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

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

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

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

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

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

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

(ii) Each application form or other form or combination of forms, other than a policy, related to one policy or to more than one similar policies, such as a series of homeowners-type policies, which form or forms are designed to define, extend, limit, exclude, condition, or otherwise alter coverage under such policy or policies.

[Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-010, filed 10/6/82.]

WAC 284-14-020 Filing transmittal information.

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

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

(ii) Whether the form is being filed for approval or as a certified filing;

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

Sample transmittal forms, that may be used in conjunction with company letterhead, are available from the office of insurance commissioner.

[Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-020, filed 10/6/82.]

Chapter 284-15 WAC SURPLUS LINE INSURANCE

WAC

284-15-010	Brokers—Surplus line—Qualifications and examination.
284-15-020	Surplus line broker—Solvent insurer required.
284-15-030	Surplus line brokers' form to be filed—Contract stamp to be used.
284-15-040	Form for surplus line insurer to designate person to receive legal process.
284-15-050	Surplus line—Waiver of financial requirements.
284-15-080	Relationship between surplus line broker and insurance agent.
284-15-090	Financial requirements for unauthorized foreign and alien insurers increased.
284-15-100	Surplus lines limited broker.

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

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

(a) An applicant must have been licensed as a casualty-property broker in accordance with RCW 48.17.150 for not less than five years preceding the date of the application, or have received the chartered property casualty underwriter (CPCU) designation with not less than five years' experience in the insurance industry preceding the date of the application, or have not less than ten years' experience as an insurance company employee, or an employee of an insurance broker's office or other related insurance industry experience preceding the date of the application, or have other equivalent experience acceptable to the insurance commissioner.

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

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

(4) The applicant, and each surplus line broker while so licensed, must be a resident of the state of Washington.

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-010, filed 1/21/81.]

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

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

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

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

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

This documentation shall include at least the following:

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

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

(c) The surplus line broker must have at least the current NAIC annual statement or its equivalent on file for any foreign unauthorized insurer used.

[Statutory Authority: RCW 48.02.060. 81-03-082 (Order R 81-1), § 284-15-020, filed 1/21/81.]

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

- | | |
|---------------------------|------------------------------------|
| Policy or Certificate No: | Premium, including any policy fee: |
|---------------------------|------------------------------------|
1. Name and license number of filing Surplus Line Broker:
 2. Name and address of producing agent or broker (if any):
 3. Name(s) of unauthorized insurer(s):
 4. Name and address of insured:
 5. Brief statement of coverages (common trade terms may be used, e.g. "furrier's block"):

STATE OF WASHINGTON	} SS.	SURPLUS LINE BROKER'S AFFIDAVIT
COUNTY		

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

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

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

.....
(Signature of Surplus Line Broker)

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

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

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

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

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

WAC 284-15-040 Form for surplus line insurer to designate person to receive legal process. (1) RCW 48.15.150 permits service of legal process against an unauthorized insurer that is sued upon any cause of action arising in this state under any contract issued by it as a surplus line contract to be made upon the insurance commissioner. The commissioner will mail the documents of process to the insurer at its principal place of business last known to the commissioner, or to a person designated by the insurer for that purpose in the most recent document filed with the commissioner on a form prescribed by the commissioner. If such unauthorized insurer elects to designate a person to receive such legal process from the commissioner, the designation shall be filed with the commissioner in substantially the form set forth in subsection (2) of this section.

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

To the Insurance Commissioner of the state of Washington:

Pursuant to RCW 48.15.150, the undersigned Insurer hereby designates:

Name

Address

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

Executed at, this day of, 19...

(Insurer)

By

(Title)

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

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

(5) Pursuant to RCW 48.15.150, each policy issued by an unauthorized insurer as a surplus line contract must contain a provision designating the commissioner as the person upon whom service of process may be made.

[Statutory Authority: RCW 48.02.060, 81-03-082 (Order R 81-1), § 284-15-040, filed 1/21/81.]

WAC 284-15-050 Surplus line—Waiver of financial requirements. The commissioner may waive the financial requirements specified in RCW 48.15.090 in circumstances where insurance cannot be otherwise procured on risks located in this state. Except as set forth in subsection (6) of this section, at least the following information shall be submitted when a surplus line broker makes a request for the commissioner to waive the financial requirements:

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

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

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

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

(5) Written acknowledgement signed by the proposed insured to the effect that the insured is informed that the coverage is to be issued by an insurer (or insurers) which is not an authorized insurer in the state of Washington, that financial requirements for surplus line insurers otherwise applicable have been waived by all parties concerned to enable this coverage to be obtained, and that there is no protection under the Washington Insurance Guaranty Association;

(6) For jumbo accounts requiring a multiplicity of insurers, the commissioner may, in lieu of the requirements in subsections (2), (3), and (4) of this section, accept certification from an experienced surplus lines broker that

the broker has investigated the financial condition of the prospective insurers and is satisfied that they are capable of underwriting the attendant risks. Records and documents supporting the broker's certification must be maintained by the broker for the life of the policies and as long thereafter as a claim may be litigated, but in no case less than five years.

[Statutory Authority: RCW 48.02.060, 89-03-060 (Order R 89-2), § 284-15-050, filed 1/17/89; 81-03-082 (Order R 81-1), § 284-15-050, filed 1/21/81.]

WAC 284-15-080 Relationship between surplus line broker and insurance agent. When a surplus line broker accepts surplus line business from an insurance agent, as permitted by RCW 48.15.080, such agent does not thereby become the representative of the insured with respect to such business. In accord therewith:

(1) Return premiums or claim payments delivered by the surplus line broker to the insurance agent shall not be deemed to have been paid to the insured or claimant until such payments are received by the insured or claimant.

(2) Delivery of notices involving the insurance, such as cancellation or renewal notices, shall not be deemed to have been made until received by the insured. Notice to the agent is not notice to the insured. However, the agent may act on behalf of the broker in giving proper notices to the insured.

[Statutory Authority: RCW 48.02.060, 48.05.310, 48.30.010 and 48.15.080, 91-23-032 (Order R 91-7), § 284-15-080, filed 11/13/91, effective 1/1/92.]

WAC 284-15-090 Financial requirements for unauthorized foreign and alien insurers increased. (1) Pursuant to RCW 48.15.090 (2)(a) and subject to RCW 48.15.090 (2)(b) and WAC 284-15-050, the commissioner hereby increases the financial requirements set forth in RCW 48.15.090 (1)(a) with respect to unauthorized foreign insurers as follows:

(a) Beginning January 1, 1993, a surplus line broker shall not insure with any foreign insurer having less than seven million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(b) Beginning January 1, 1994, a surplus line broker shall not insure with any foreign insurer having less than eight million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(c) Beginning January 1, 1995, a surplus line broker shall not insure with any foreign insurer having less than nine million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(d) Beginning January 1, 1996, a surplus line broker shall not insure with any foreign insurer having less than ten million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(e) Beginning January 1, 1997, a surplus line broker shall not insure with any foreign insurer having less than eleven million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(f) Beginning January 1, 1998, a surplus line broker shall not insure with any foreign insurer having less than twelve million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(g) Beginning January 1, 1999, a surplus line broker shall not insure with any foreign insurer having less than thirteen million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(h) Beginning January 1, 2000, a surplus line broker shall not insure with any foreign insurer having less than fourteen million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(i) Beginning January 1, 2001, a surplus line broker shall not insure with any foreign insurer having less than fifteen million dollars of capital and surplus or substantially equivalent capital funds, of which not less than one million five hundred thousand dollars is capital.

(2) The commissioner hereby advises that the financial requirement imposed by RCW 48.15.090 (1)(b) with respect to unauthorized alien insurers is increased. Beginning January 1, 1993, a surplus line broker shall not insure with any alien insurer having less than fifteen million dollars of capital and surplus or substantially equivalent capital funds, subject to WAC 284-15-050 with respect to a waiver pursuant to RCW 48.15.090 (2)(b).

[Statutory Authority: RCW 48.02.060, 92-24-062 (Order R 92-24), § 284-15-090, filed 11/30/92, effective 12/31/92.]

WAC 284-15-100 Surplus lines limited broker. (1) A person who is not a resident of Washington may be licensed as a limited surplus lines broker.

(2) A limited surplus lines broker may act in soliciting, negotiating, or procuring insurance, but only liability insurance and only on behalf of a purchasing group registered in accordance with RCW 48.92.080.

(3) To be licensed as a limited surplus lines broker, a person must meet all the same qualifications (other than residency) as any other person seeking to be licensed as a surplus lines broker under chapter 48.15 RCW and chapter 284-15 WAC (including passing the Washington examination), and has all the same responsibilities as any other surplus lines broker.

[Statutory Authority: RCW 48.02.060 and 48.92.140, 93-19-008 (Order R 93-12), § 284-15-100, filed 9/1/93, effective 10/2/93.]

**Chapter 284-16 WAC
INSURERS**

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-16-010 Health care services—Certificates of registration. [Rule made 5/25/55, filed with code reviser 3/22/60.] Repealed by Order R-68-2, filed 5/1/68.
- 284-16-050 Accounting for salvage and subrogation recoveries, annual statement. [Order R-76-3, § 284-16-050, filed 7/26/76.] Repealed by 92-22-075 (Order 92-11), filed 11/2/92, effective 12/3/92. Statutory Authority: RCW 48.02.060.
- 284-16-060 Disability insurance—Minimum reserve standards. [Order 282, filed 7/22/66.] Repealed by 92-19-038 (Order R 92-8), filed 9/9/92, effective 10/10/92. Statutory Authority: RCW 48.02.060.

TITLE INSURERS

WAC 284-16-030 Title insurers—Defining "complete set of tract indexes." (1) The phrase "a complete set of tract indexes," as used in RCW 48.29.020 and 48.29.040, is defined to mean a set of indexes from which the record ownership and condition of title to all land within the particular county can be traced and ascertained, such set of indexes to be complete from the inception of title from the United States of America.

(2) The basic component parts of such a set of indexes are:

(a) An index or indexes in which the reference is to geographic subdivisions of land, classified according to legal description (as distinguished from an index or indexes in which the reference is to the name of the title holder, commonly called a grantor-grantee index) wherein notations of or references to:

(i) All filed or recorded instruments affecting title to particularly described parcels of real property and which impart constructive notice under the recording laws; and

(ii) All judicial proceedings in the particular county affecting title to particularly described parcels of real property are posted, filed, entered or otherwise included in that part of the indexing system which designates the particular parcel of real property; provided, no reference need be made in such index to any judicial proceeding which is referred to or noted in the name index defined in subparagraph (b) below.

(b) A name index or indexes wherein notations of or references to all instruments, proceedings and other matters of record in the particular county which affect or may affect title to all real property (as distinguished from particularly described parcels of real property) of the person, partnership, corporation or other entity named therein and affected thereby, are posted, filed, entered or otherwise included in that part of the indexing system which designates that name.

(3) The indexes prescribed in numbered subsection (2) above, may be maintained in bound books, loose-leaf books, jackets or folders, on card files, or in any other form or system, whether manual, mechanical, electronic or otherwise; or in any combination of such forms or systems.

(4) The extent to which the prescribed indexes shall be sub-divided or defined is dependent upon all relevant circumstances. The population of the particular county, the extent to which land within the particular county has been subdivided and passed into separate ownerships, and all other factors which are reasonably related to the purpose of the statutory requirement, are entitled to consideration in such determination.

[Order 127, adopted 12/12/60, filed 12/14/60.]

CERTAIN REAL ESTATE ISSUES

WAC 284-16-100 Investments—Encumbrance—Interpretation of RCW 48.13.130. With reference to RCW 48.13.130 entitled "Encumbrance" defined, it has recently come to my attention that there has been some difficulty in the application of this provision of the code with reference to restrictions and covenants, particularly the words "common to the community in which the property is located." It has been found that restrictions and covenants are different in tracts, plats, maps or other subdivisions of land in the same community. Pursuant to the authority vested in me in RCW 48.02.060, the following ruling is hereby made, interpreting RCW 48.13.130 as follows:

(1) The wording "common to the community in which the property is located" may be regarded as applying only to the tract, plat, map, or other subdivision of land in which the real property is located.

(2) Where any right of reversion is outstanding and where a specific waiver thereof is not obtainable, the lender may consider such right not to be an "encumbrance" under the code: *Provided*, A title insurance company, authorized to transact such business within the state in which the real property involved is situated, shall specifically indemnify the lender against any loss or damage arising as a result of such right.

[Rule made 5/15/53, filed 3/22/60.]

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Reviser's note: Subsection (1) above is an interpretation of RCW 48.13.130 before it was revised by section 2, chapter 303, Laws of 1955. The old section contained the phrase "common to the community in which the property is located."

WAC 284-16-110 F.H.A. mortgage loans and investments. Whereas, under the provisions of the insurance code of the state of Washington which became effective as of October 1, 1947, certain limitations are placed upon the amount of money which may be loaned by domestic insurers upon the security of a mortgage upon real estate with relation to the value of such real estate, and which limitations should not be made applicable to mortgages which the federal housing administrator has insured or has made a commitment to insure, and Whereas, it is desirable that domestic insurers be able to continue to exercise the privilege of investing in or making loans upon such federal housing administration insured mortgages as was permissible under laws in force immediately prior to October 1, 1947; now therefore, it is hereby ordered:

(1) That until further order of the insurance commissioner, and pursuant to the provisions of RCW 48.13.250, consent is hereby given to domestic insurers, any other provision of the insurance code notwithstanding, to invest in or loan upon the security of real estate mortgages which the federal housing administrator has insured or has made a commitment to insure, and to make such other investments and loans, all as provided in RCW 39.60.010.

(2) That such investments or loans may be credited toward investments of minimum capital, surplus, or reserves as required by RCW 48.13.260.

[Order 1001, issued 10/2/47, filed 3/22/60.]

VALUATION OF STOCK OF SUBSIDIARY

WAC 284-16-150 Purpose. The purpose of this regulation, WAC 284-16-150 through 284-16-220, is to implement RCW 48.12.180(3) by establishing rules for the valuation of stock of a subsidiary of an insurer.

[Order R 76-7, § 284-16-150, filed 11/30/76.]

WAC 284-16-160 Definitions. For purpose of this regulation: (1) The term "subsidiary" shall have the same meaning given it by RCW 48.31A.010;

(2) The term "book value" shall mean that value determined by dividing the amount of its capital and surplus as shown in its last annual statement or subsequent report of examination (excluding from surplus, reserves required by statute and any portion of surplus properly allocable to policyholders, rather than stockholders) less the value (par of redemption value, whichever is the greater) of all of its preferred stock, if any, outstanding, by the number of shares of its common stock issued and outstanding.

[Order R 76-7, § 284-16-160, filed 11/30/76.]

WAC 284-16-170 Usual valuation of stock of a subsidiary. The common stock of any subsidiary of an insurer may always be valued on the basis of the value of only such of the assets of such subsidiary as would consti-

tute lawful investments for the insurer if acquired or held directly by the insurer.

[Order R 76-7, § 284-16-170, filed 11/30/76.]

WAC 284-16-180 Other methods of valuing stock of a subsidiary. If sound business judgment of an insurer's management causes it to believe that a valuation of common stock of a subsidiary pursuant to WAC 284-16-170 is inappropriate, it may value such stock on one of the following bases:

(1) "Book value," provided, however, that the common of a noninsurance company may not be valued on the basis of this subsection, and further provided that an insurer may value its holdings of stock in a subsidiary insurer at acquisition cost if acquisition cost is less than market or book value.

(2) One of the following bases appropriate to each type of subsidiary owned by it, provided, however, that an insurer shall not be required to value the stock of all its subsidiaries on the same basis:

(a) Subject to the limitations imposed under WAC 284-16-190, the net worth of a noninsurance company determined in accordance with generally accepted accounting principles, as of the end of its most recent fiscal year, provided, subject to WAC 284-16-200, that the financial statements of the company for its most recent fiscal year have been audited by an independent certified public accountant in accordance with generally accepted auditing standards. The common stock of an insurance company may not be valued under this subsection.

(b) Subject to the limitations imposed under WAC 284-16-190, a value equal to the cost of the common stock of the subsidiary, provided such value is determined and adjusted to reflect subsequent operating results, in the case of insurance companies in accordance with statutory accounting requirements, and for other than insurance companies in accordance with generally accepted accounting principles.

(c) The market value of the common stock of the subsidiary, if the stock is listed on a national securities exchange.

(d) The value, if any, placed on the common stock of such subsidiary by the National Association of Insurance Commissioners.

(e) Any other value which the insurer can substantiate to the satisfaction of the commissioner as being a reasonable value.

[Order R 76-7, § 284-16-180, filed 11/30/76.]

WAC 284-16-190 Limitation on values. (1) With respect to values determined under WAC 284-16-180 (2)(a) or (b), amounts attributable to "good will," and other intangibles shall not in the aggregate (of all direct and indirect subsidiaries) exceed (either initially on acquisition of a subsidiary, or thereafter), 10% of the capital and surplus of an insurer, as reported in its next preceding annual statement. Such amounts shall be written off over a period not in excess of ten years.

(2) For purposes of this section, "good will" shall be defined as the amount arising at a given point in time, resulting from an arm's-length transaction involving the transfer of a business, representing the difference between

the value of the consideration given and the net asset value of the properties acquired on the books of the predecessor company.

(3) Where warranted in exceptional cases, the commissioner may require a more rapid write-off of good will than is otherwise provided in this section.

[Order R 76-7, § 284-16-190, filed 11/30/76.]

WAC 284-16-200 Additional provisions. (1) Within 90 days after the effective date of this regulation, a domestic insurer using a method of valuation permitted by WAC 284-16-180 shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for each of its subsidiaries.

(2) Within 30 days after the acquisition of a subsidiary, a domestic insurer shall file with the commissioner relevant information identifying, supporting and justifying the value of, and the basis of valuation used in accordance with the provisions of this regulation for such subsidiary.

(3) A valuation basis used for a subsidiary shall thereafter be consistently used unless a change is substantiated as reasonable and on that basis is approved in writing by the commissioner.

(4) If a subsidiary is valued on the basis of WAC 284-16-180 (2)(a) and the books of the subsidiary are not audited at the time the valuation is included in the insurer's annual statement, the insurer shall thereafter report and explain the differences, if any, between the value of the subsidiary as reported in the annual statement and the value as determined by audit. Such report and explanation shall be made as soon as possible following such audit.

(5) If any subsidiary, which is not itself an insurance company, is valued other than on the basis of market value, there shall be deducted from the otherwise determined value a sum equal to the value claimed for any of its assets which would not constitute admitted assets for the insurer if held directly by the insurer, if such assets:

(a) Are held by the subsidiary but used, under a lease arrangement or otherwise, significantly in the conduct of the insurer's business; or

(b) Were acquired from or purchased for the benefit or use of the insurer by the subsidiary under circumstances that, in the opinion of the commissioner, support a finding that the primary purpose of such acquisition or purchase was the evasion or avoidance of RCW 48.12.010 or 48.12.020.

[Order R 76-7, § 284-16-200, filed 11/30/76.]

WAC 284-16-210 Adjustment procedure. The commissioner may, after notice and opportunity to be heard, determine that the basis used for valuation of the stock of any subsidiary does not, under the specific circumstances of the case, reflect the value of the subsidiary and may order either an adjustment in valuation or the use of one of the other specified bases of valuation.

[Order R 76-7, § 284-16-210, filed 11/30/76.]

WAC 284-16-220 Cumulative limitations. Except as modified by this regulation, applicable cumulative limitations of chapter 48.13 RCW shall continue to apply.

[Order R 76-7, § 284-16-220, filed 11/30/76.]

FINANCIALLY HAZARDOUS CONDITION

WAC 284-16-300 Purpose. (1) The purpose of this regulation, WAC 284-16-300 through 284-16-320 is to set forth the standards which the commissioner will use to identify insurers in such condition as to render the continuance of their business hazardous to the public or to holders of their policies or certificates of insurance.

(2) This regulation shall not be interpreted to limit the powers granted the commissioner by any laws or parts of laws of this state, nor shall this regulation be interpreted to supersede any laws or parts of laws of this state.

[Statutory Authority: RCW 48.02.060, 92-19-039 (Order R 92-9), § 284-16-300, filed 9/9/92, effective 10/10/92.]

WAC 284-16-310 Standards. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors, or the general public. The commissioner may consider:

(1) Adverse findings reported in financial condition and market conduct examination reports.

(2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its related reports.

(3) The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus.

(4) The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature.

(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

(6) The insurer's operating loss in the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required.

(7) Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation.

(8) Contingent liabilities, pledges, or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer.

(9) Whether any controlling person of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

(10) The age and collectibility of receivables.

(11) Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished misleading information concerning an inquiry.

(13) Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

(14) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

(15) Whether the company has experienced or will experience in the foreseeable future, cash flow and/or liquidity problems.

[Statutory Authority: RCW 48.02.060, 92-19-039 (Order R 92-9), § 284-16-310, filed 9/9/92, effective 10/10/92.]

WAC 284-16-320 Manner in which commissioner will exercise authority. (1) For the purpose of making a determination of an insurer's financial condition under this regulation, the commissioner may:

(a) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding;

(b) Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates;

(c) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; or

(d) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

(2) If the commissioner determines that the continued operation of the insurer authorized to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may, in conjunction with or in lieu of a notice required or permitted by RCW 48.05.150, issue an order requiring the insurer to:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(b) Reduce, suspend, or limit the volume of business being accepted or renewed;

(c) Reduce general insurance and commission expenses by specified methods;

(d) Increase the insurer's capital and surplus;

(e) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(f) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary;

(h) Document the adequacy of premium rates in relation to the risks insured; or

(i) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the commissioner.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

(3) Any insurer subject to an order under subsection (2) of this section may make a written demand for a hearing, subject to the requirements of RCW 48.04.010, by specifying in what respects it is aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

[Statutory Authority: RCW 48.02.060. 92-19-039 (Order R 92-9), § 284-16-320, filed 9/9/92, effective 10/10/92.]

MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP DISABILITY INSURANCE CONTRACTS

WAC 284-16-400 Title and scope. (1) This regulation, WAC 284-16-400 through 284-16-540, shall be known and may be cited as the "Washington minimum reserve standards for individual and group disability insurance contracts regulation."

(2) These standards apply to all individual and group disability insurance coverages except medicare supplement insurance as governed by WAC 284-66-210.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-400, filed 9/9/92, effective 10/10/92.]

WAC 284-16-410 Definitions. For the purpose of this regulation, the following definitions shall apply:

(1) "Annual-claim cost" means the net annual cost per unit of benefit before the addition of expense including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a one hundred dollar monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age thirty-five, in a certain occupation might be twelve dollars, while the gross premium for this benefit might be eighteen dollars. The additional six dollars would cover expense and profit or contingencies.

(2) "Claims accrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for accrued benefits. A claim reserve, which represents an estimate of this accrued claim liability, must be established.

(3) "Claims incurred" means that portion of a claim for which the insurer has become obligated to make payment, on or prior to the valuation date.

(4) "Claims reported" means those claims that have been incurred on or prior to the valuation date of which the insurer has been informed, on or prior to the valuation date. These claims are considered as reported claims for annual statement purposes.

(5) "Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which result in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made, which may or may not be discounted with interest, must be established.

(6) "Claims unreported" means those claims that have been incurred on or prior to the valuation date of which the insurer has not been informed, on or prior to the valuation date. These claims are considered as unreported claims for annual statement purposes.

(7) "Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

(8) "Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(9) "Gross premium" is the amount of premium charged by the insurer. It includes the net premium, based on claim-cost, for the risk, together with any loading for expenses, profit, or contingencies.

(10) "Group insurance" includes blanket disability insurance.

(11) "Level premium" means a premium calculated to remain unchanged throughout either the lifetime of the policy, or for some shorter projected period of years. The premium need not be guaranteed; in which case, although it is calculated to remain level, it may be changed if any of the assumptions on which it was based are revised at a later time. Generally, the annual claim costs are expected to increase each year and the insurer, instead of charging premiums that correspondingly increase each year, charges a premium calculated to remain level for a period of years or for the lifetime of the contract. In this case the benefit portion of the premium is more than needed to provide for the cost of benefits during the earlier years of the policy and less than the actual cost in the later years. The building of a prospective contract reserve is a natural result of level premiums.

(12) "Long-term care insurance" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services over a prolonged period of time for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Long-term care insurance may be issued by insurers; fraternal benefit societies; health care service contractors; health maintenance organizations or any similar organization

to the extent they are authorized. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, nor shall it include a contract between a continuing care retirement community and its residents.

(13) "Modal premium" means the premium paid on a contract based on a premium term which could be annual, semi-annual, quarterly, monthly, or weekly. Thus if the annual premium is one hundred dollars and if, instead, monthly premiums of nine dollars are paid then the modal premium is nine dollars.

(14) "Negative reserve" means a negative terminal reserve value. Negative reserves occur when the present value of future benefits is less than the present value of future valuation net premiums.

(15) "Preliminary term reserve method" means the method of valuation for which the valuation net premium for each year falling within the preliminary term period is exactly sufficient to cover the expected incurred claims of that year, so that the terminal reserves will be zero at the end of the year. As of the end of the preliminary term period, a new constant valuation net premium, or stream of changing valuation premiums, becomes applicable such that the present value of all such premiums is equal to the present value of all claims expected to be incurred following the end of the preliminary term period.

(16) "Present value of amounts not yet due on claims" means the reserve for claims unaccrued which may be discounted at interest.

(17) "Reserve" includes all items of benefit liability, whether in the nature of incurred claim liability or in the nature of contract liability relating to future periods of coverage, and whether the liability is accrued or unaccrued. An insurer under its contracts promises benefits which result in:

(a) Claims which have been incurred, that is, for which the insurer has become obligated to make payment, on or prior to the valuation date. On these claims, payments expected to be made after the valuation date for accrued and unaccrued benefits are liabilities of the insurer which should be provided for by establishing claim reserves; or

(b) Claims which are expected to be incurred after the valuation date. Any present liability of the insurer for these future claims should be provided for by the establishment of contract reserves and unearned premium reserves.

(18) "Terminal reserve" means the reserve at the end of a contract year, which is the present value of benefits expected to be incurred after that contract year minus the present value of future valuation net premiums.

(19) "Unearned premium reserve" means that portion of the premium paid or due to the insurer which is applicable to the period of coverage extending beyond the valuation date. Thus if an annual premium of one hundred twenty dollars was paid on November 1, twenty dollars would be earned as of December 31 and the remaining one hundred dollars would be unearned. The unearned premium reserve could be on a gross basis as in this example, or on a valuation net premium basis.

(20) "Valuation net modal premium" means the modal fraction of the valuation net annual premium that corresponds to the gross modal premium in effect on any contract to which contract reserves apply. Thus if the mode of

payment in effect is quarterly, the valuation net modal premium is the quarterly equivalent of the valuation net annual premium.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-410, filed 9/9/92, effective 10/10/92.]

WAC 284-16-420 Reserves in excess of minimum reserve standards. When an insurer determines that adequacy of its disability insurance reserves requires reserves in excess of the minimum standards specified herein, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-420, filed 9/9/92, effective 10/10/92.]

WAC 284-16-430 Prospective gross premium valuation. (1) With respect to any block of contracts, or with respect to an insurer's disability business as a whole, a prospective gross premium valuation is the ultimate test of reserve adequacy as of a given valuation date. The gross premium valuation shall take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date, adjusted for future premium increases reasonably expected to be put into effect, of:

- (a) All expected benefits unpaid;
- (b) All expected expenses unpaid; and
- (c) All unearned or expected premiums.

(2) The insurer shall perform gross premium valuation whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's disability business as a whole. In the event inadequacy is found to exist, the insurer shall make immediate loss recognition and restore the reserves to adequacy. The insurer shall hold adequate reserves, inclusive of claim, premium and contract reserves, if any, with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(3) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-430, filed 9/9/92, effective 10/10/92.]

WAC 284-16-440 General claim reserve requirements. (1) Claim reserves are required for all incurred but unpaid claims on all disability insurance policies;

(2) Appropriate claim expense reserves are required with respect to the estimated expense of settlement of all incurred but unpaid claims; and

(3) All such reserves for prior valuation years are to be tested for adequacy and reasonableness along the lines of claim runoff schedules in accordance with the statutory financial statement including consideration of any residual unpaid liability.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-440, filed 9/9/92, effective 10/10/92.]

WAC 284-16-450 Minimum standards for claim reserves. (1) For disability income:

(a) The maximum interest rate for claim reserves is specified in WAC 284-16-520.

(b) Minimum standards with respect to morbidity are those specified in WAC 284-16-500 and 284-16-510; except that, at the option of the insurer, for claims with a duration from date of disablement of less than two years, reserves may be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) For contracts with an elimination period, the insurer shall measure the duration of disablement as dating from the time that benefits would have begun to accrue had there been no elimination period.

(2) For all other benefits:

(a) The maximum interest rate for claim reserves is specified in WAC 284-16-520.

(b) The insurer shall base the reserve on the insurer's morbidity experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(c) General claim reserve methods are as follows:

(i) The insurer may use any generally accepted or reasonable actuarial method or combination of methods to estimate all claim liabilities.

(ii) The methods used for estimating liabilities generally may be aggregate methods, or various reserve items may be separately valued. The insurer may also employ approximations based on groupings and averages. The insurer shall, however, determine adequacy of the claim reserves in the aggregate.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-450, filed 9/9/92, effective 10/10/92.]

WAC 284-16-460 Premium reserves. (1) General premium reserve requirements are:

(a) Unearned premium reserves are required for all contracts, including credit insurance disability contracts, with respect to the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation;

(b) If premiums due and unpaid are carried as an asset, the insurer shall treat the premiums as premiums in force, subject to unearned premium reserve determination. The insurer shall carry as an offsetting liability the value of unpaid commissions, premium taxes, and the cost of collection associated with due and unpaid premiums; and

(c) Insurers may appropriately discount to the valuation date the gross premiums paid in advance for a period of coverage commencing after the next premium due date which follows the date of valuation. The insurer shall hold this discounted premium either as a separate liability or as an addition to the unearned premium reserve which would otherwise be required as a minimum.

(2) Minimum standards for unearned premium reserves are as follows:

(a) The minimum unearned premium reserve with respect to any contract is the pro rata unearned modal premium that applies to the premium period beyond the

valuation date, with such premium determined on the basis of:

(i) The valuation net modal premium on the contract reserve basis applying to the contract; or

(ii) The gross modal premium for the contract if no contract reserve applies.

(b) However, in no event may the sum of the unearned premium and contract reserves for all contracts of the insurer subject to contract reserve requirements be less than the gross modal unearned premium reserve on all such contracts, as of the date of valuation. Such reserve shall never be less than the expected claims for the period beyond the valuation date represented by such unearned premium reserve, to the extent not provided for elsewhere.

(3) General premium reserve methods are as follows: In computing premium reserves, the insurer may employ suitable approximations and estimates; including, but not limited to groupings, averages, and aggregate estimation. The insurer shall periodically test the approximations or estimates to determine their continuing adequacy and reliability.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-460, filed 9/9/92, effective 10/10/92.]

WAC 284-16-470 Contract reserves. (1) General contract reserve requirements are:

(a) Contract reserves are required, unless otherwise specified in (b) of this subsection for:

(i) All individual and group contracts with which level premiums are used; or

(ii) All individual and group contracts with respect to which, due to the gross premium pricing structure at issue, the value of the future benefits at any time exceeds the value of any appropriate future valuation net premiums at that time. The insurer shall determine the values specified in this item (ii) on the basis specified in subsection (2) of this section.

(b) Contracts not requiring a contract reserve are:

(i) Contracts which cannot be continued after one year from issue; or

(ii) Contracts already in force on the effective date of these standards for which no contract reserve was required under the immediately preceding standards.

(c) The contract reserve is in addition to claim reserves and premium reserves; and

(d) The insurer shall use methods and procedures for contract reserves that are consistent with those for claim reserves for any contract, or else shall make appropriate adjustment when necessary to assure provision for the aggregate liability. The insurer shall use the same definition of the date of incurral in both determinations.

(2) The basis for determining minimum standards for contract reserves are:

(a) Minimum standards with respect to morbidity are those set forth in WAC 284-16-500 and 284-16-510. Valuation net premiums used under each contract must have a structure consistent with the gross premium structure at issue of the contract as this relates to advancing age of insured, contract duration and period for which gross premiums have been calculated. The insurer shall value contracts for which tabular morbidity standards are not

specified in WAC 284-16-500 and 284-16-510 using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) The maximum interest rate is specified in WAC 284-16-520.

(c) The insurer shall use termination rates in the computation of reserves on the basis of a mortality table as specified in WAC 284-16-530 except as noted in (d) of this subsection.

(d) Under contracts for which premium rates are not guaranteed, and where the effects of insurer underwriting are specifically used by policy duration in the valuation morbidity standard, the insurer may use total termination rates at ages and durations where these exceed specified mortality table rates, but not in excess of the lesser of:

(i) Eighty percent of the total termination rate used in the calculation of the gross premiums; or

(ii) Eight percent.

(e) Where a morbidity standard specified in WAC 284-16-500 and 284-16-510 is on an aggregate basis, the insurer may adjust the morbidity standard to reflect the effect of insurer underwriting by policy duration. The adjustments shall be appropriate to the underwriting and be acceptable to the commissioner.

(f) Reserve method:

(i) For insurance, except long-term care and Medicare supplement insurance, the minimum reserve is the reserve calculated on the two-year full preliminary term method; that is, under which the terminal reserve is zero at the first and also the second contract anniversary.

(ii) For long-term care insurance and medicare supplemental insurance as governed by WAC 284-66-210 the minimum reserve is the reserve calculated on the one-year full preliminary term method.

(g) The preliminary term method may be applied only in relation to the date of issue of a contract. Reserve adjustments introduced later, as a result of rate increases, revisions in assumptions or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis.

(h) The insurer may offset negative reserves on any benefit against positive reserves for other benefits in the same contract, but the total contract reserve with respect to all benefits combined may not be less than zero.

(3) Provided the contract reserve on all contracts to which an alternative method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above; an insurer may use any reasonable assumptions as to interest rates, termination and/or mortality rates, and rates of morbidity or other contingency. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such contracts, including, but not limited to the following:

(a) The net level premium method;

(b) The one-year full preliminary term method;

(c) Prospective valuation on the basis of actual gross premiums with reasonable allowances for future expenses;

(d) The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity, grouping of similar contract forms;

(e) The computation of the reserve for one contract benefit as a percentage of, or by other relation to, the aggregate contract reserves exclusive of the benefit or benefits so valued; and

(f) The use of a composite annual claim cost for all or any combination of the benefits included in the contracts valued.

(4) Tests for adequacy and reasonableness of contract reserves.

(a) Annually, the insurer shall make an appropriate review of the insurer's prospective contract liabilities on contracts valued by tabular reserves, to determine the continuing adequacy and reasonableness of the tabular reserves giving consideration to future gross premiums. The insurer shall make appropriate increments to such tabular reserves if such tests indicate that the basis of such reserves is no longer adequate; subject, however, to the minimum standards of subsection (2) of this section.

(b) If an insurer has a contract or a group of related similar contracts, for which future gross premiums will be restricted by contract, commissioner's regulation, or for some other reasons, such that the future gross premiums reduced by expenses for administration, commissions, and taxes will be insufficient to cover future claims, the insurer shall establish contract reserves for such shortfalls in the aggregate.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-470, filed 9/9/92, effective 10/10/92.]

WAC 284-16-480 Determination of adequacy. The insurer shall determine the adequacy of its disability insurance reserves on the basis of the claim reserves, premium reserves, and contract reserves combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-480, filed 9/9/92, effective 10/10/92.]

WAC 284-16-490 Reinsurance. Increases to, or credits against reserves carried, arising because of reinsurance assumed or reinsurance ceded, must be determined in a manner consistent with these minimum reserve standards and with all applicable provisions of the reinsurance contracts which affect the insurer's liabilities.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-490, filed 9/9/92, effective 10/10/92.]

WAC 284-16-500 Specific minimum morbidity standards for individual disability contracts. (1) Disability income benefits due to accident or sickness.

(a) Contract reserves for:

(i) Contracts issued on or after January 1, 1967, and prior to January 1, 1986: The 1964 Commissioners Disability Table (64 CDT).

(ii) Contracts issued on or after January 1, 1993: The 1985 Commissioners Individual Disability Tables A (85CIDA); or The 1985 Commissioners Individual Disability Tables B (85CIDB).

(iii) Contracts issued during 1986 through December 31, 1992: Optional use of either the 1964 Table or the 1985 Tables.

(iv) Each insurer shall elect, with respect to all individual contracts issued in any one statement year, either it will use Tables A or Tables B as the minimum standard. The insurer may, however, elect to use the other tables with respect to any subsequent statement year.

(b) Claim reserves: The minimum morbidity standard in effect for contract reserves on currently issued contracts, as of the date the claim is incurred.

(2) Hospital benefits, surgical benefits and maternity benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves for:

(i) Contracts issued on or after January 1, 1967, and before January 1, 1986: The 1956 Intercompany Hospital-Surgical Tables.

(ii) Contracts issued on or after January 1, 1993: The 1974 Medical Expense Tables, Table A, Transactions of the Society of Actuaries, Volume XXX, pg. 63. Refer to the paper (in the same volume, pg. 9) to which this table is appended, including its discussions, for methods of adjustment for benefits not directly valued in Table A: "Development of the 1974 Medical Expense Benefits," Houghton and Wolf.

(iii) Contracts issued during 1986 through December 31, 1992: Optional use of the 1974 Medical Expense Tables.

(b) Claim reserves: No specific standards. See subsection (5) of this section.

(3) Cancer expense benefits (scheduled benefits or fixed time period benefits only).

(a) Contract reserves for:

(i) Contracts issued on or after January 1, 1993: The 1985 NAIC Cancer Claim Cost Tables.

(ii) Contracts issued during 1986 through December 31, 1992: Optional use of the 1985 NAIC Cancer Claim Cost Tables.

(b) Claim reserves: No specific standard. See subsection (5) of this section.

(4) Accidental death benefits.

(a) Contract reserves for contracts issued on or after January 1, 1967: The 1959 Accidental Death Benefits Table.

(b) Claim reserves: Actual amount incurred.

(5) Other individual contract benefits.

(a) Contract reserves: For all other individual contract benefits, morbidity assumptions are to be determined using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) Claim reserves: For all benefits other than disability, claim reserves are to be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-500, filed 9/9/92, effective 10/10/92.]

WAC 284-16-510 Specific minimum morbidity standards for group disability contracts. (1) Disability income benefits due to accident or sickness.

(a) Contract reserves for:

(i) Contracts issued prior to January 1, 1993: The same basis, if any, as that employed by the insurer as of December 31, 1992;

(ii) Contracts issued on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT).

(b) Claim reserves for:

(i) Claims incurred on or after January 1, 1993: The 1987 Commissioners Group Disability Income Table (87CGDT);

(ii) Claims incurred prior to January 1, 1993: Optional use of either the 1964 Table or the 1987 Table.

(2) Other group contract benefits.

(a) Contract reserves: For all other group contract benefits, morbidity assumptions are to be determined using tables established for reserve purposes by a qualified actuary and acceptable to the commissioner.

(b) Claim reserves: For all benefits other than disability, claim reserves are to be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-510, filed 9/9/92, effective 10/10/92.]

WAC 284-16-520 Specific standards for interest.

(1) For contract reserves the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance issued on the same date as the disability insurance contract.

(2) For claim reserves the maximum interest rate is the maximum rate permitted by law in the valuation of life insurance issued on the same date as the claim incurral date.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-520, filed 9/9/92, effective 10/10/92.]

WAC 284-16-530 Specific standards for mortality.

The mortality basis used shall be according to a table, but without use of selection factors, permitted by law for the valuation of whole life insurance issued on the same date as the disability insurance contract.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-530, filed 9/9/92, effective 10/10/92.]

WAC 284-16-540 Reserves for waiver of premium.

(1) Waiver of premium reserves involve several special considerations. First, many disability valuation tables are based on exposures that include contracts on premium waiver as in-force contracts. Hence, contract reserves based on these tables are not reserves on "active lives" but rather reserves on contracts "in force." This is true for the 1964 CDT and for both the 1985 CIDA and CIDB Tables.

(2) Accordingly, tabular reserves using any of these tables should value reserves on the following basis:

(a) Claim reserves should include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

(b) Premium reserves should include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

(c) Contract reserves should include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

(3) If an insurer is, instead, valuing reserves on what is truly an active life table, or if a specific valuation table is not being used but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, then it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis should carefully consider, however, whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

[Statutory Authority: RCW 48.02.060. 92-19-038 (Order R 92-8), § 284-16-540, filed 9/9/92, effective 10/10/92.]

Chapter 284-17 WAC

LICENSING REQUIREMENTS AND PROCEDURES

WAC

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- 284-17-010 Application. [Order R-68-12, § 284-17-010, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-020 Definitions. [Order R-68-12, § 284-17-020, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-030 Prohibited actions. [Order R-68-12, § 284-17-030, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-040 Filings required. [Order R-68-12, § 284-17-040, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-045 Review not approval. [Order R-68-12, § 284-17-045, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-050 Filing precondition to solicitation. [Order R-68-12, § 284-17-050, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-060 Exclusions. [Order R-68-12, § 284-17-060, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-070 Examination powers not diminished. [Order R-68-12, § 284-17-070, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-080 Enforcement. [Order R-68-12, § 284-17-080, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-090 Severability. [Order R-68-12, § 284-17-090, filed 1/13/69.] Repealed by Order R77-4, filed 6/17/77.
- 284-17-100 Agent, solicitor or adjuster examination scheduling and fees. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-100, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060.
- 284-17-110 Reexamination after failure to pass examination. [Statutory Authority: RCW 48.02.060. 80-01-011 (Order R 79-6), § 284-17-110, filed 12/12/79.] Repealed by 82-10-016 (Order R 82-2), filed 4/28/82. Statutory Authority: RCW 48.02.060.

EXAMINATIONS

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
Property/casualty and disability agent or solicitor	Property, casualty, disability
Life/disability/ property/casualty 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	Adjuster
Public adjuster	Adjuster
Life and disability broker	Life and disability
Property/casualty broker	Property and casualty (Disability questions are included)

(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 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, two finger print cards, appointment form(s) for each insurer represented, the appropriate license, appointment and filing fees.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-120, filed 6/28/94, effective 7/29/94. 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 284-17-121 Qualifications of agents of insurers authorized to transact more than one line of insurance—Exceptions. (1) Except as provided in subsection (2) of this section, applicants for agents' licenses must take and pass a qualifying examination for all those lines of insurance which the appointing insurer is authorized to transact in the state of Washington.

(2) Insurers authorized to write lines of insurance in addition to vehicle insurance or surety insurance may appoint agents to write vehicle insurance or surety insurance only, and such appointees may take a qualifying examination for vehicle insurance or surety insurance only: *Provided, however,* That the appointing insurers shall file with this office a written statement in which they agree to accept from such appointees only vehicle or surety insurance, as the case may be, until such time as these appointees have qualified to write additional lines of insurance and the insurers have verified such qualification.

(3) Insurers making appointments limited to vehicle insurance or surety insurance only must indicate such

limitation clearly on each appointment form. In the event persons holding a license for vehicle or surety insurance only subsequently qualify for the additional lines of insurance authorized to be written by their appointing insurers, these insurers must file a new appointment form for each such agent and pay the regular appointment fee for each.

(4) This section does not apply to or affect the "limited licenses" permitted by RCW 48.17.190.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-121, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-121, filed 2/2/90, effective 3/5/90.]

WAC 284-17-122 Nonresident agent, broker, or adjuster's licenses. (1) Applicants who are not residents of Washington may be licensed as nonresident agents or brokers if:

(a) The applicant has and maintains a similar license in the state of residence for the lines of insurance defined in Washington's insurance statutes; and

(b) The state of residence reciprocates and licenses Washington's agents and brokers as nonresident agents or brokers.

(2) Applicants who are not residents of Washington may be licensed as nonresident adjusters if:

(a) The applicant has and maintains an adjuster's license in the state of residence; and

(b) The state of residence reciprocates and licenses Washington's adjusters as nonresident adjusters.

If an applicant's state of residence does not issue an adjuster's license, the applicant must pass this state's written adjuster's examination.

(3) All applicants for a nonresident license must provide written certification from the insurance department of their state of residence indicating:

(a) All currently active license(s) held by an applicant;

(b) The lines of insurance for which the agent or broker has qualified to sell; and

(c) All disciplinary actions taken against the applicant.

[Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-122, filed 2/2/90, effective 3/5/90.]

WAC 284-17-123 Adjuster's licenses. (1) Applicants for a resident adjuster's license may satisfy the experience or special training requirements of RCW 48.17.380(4) by employment as a "trainee" for a period of not less than six months.

(2) Each "trainee" shall be under the supervision of a resident licensed adjuster. "Trainees" shall receive training in all adjustment activities and responsibilities. Activities of the "trainee" shall be restricted to participation in factual investigation and tentative closing of losses. All adjusting transactions shall be in the name of the supervising licensed adjuster who shall review, confirm, and be responsible for all acts of the "trainee." Compensation of a "trainee" shall be on a salary basis only.

(3) Anyone employing trainees shall immediately advise the insurance commissioner by letter of such employment, giving the exact date of employment of each "trainee." The employer shall enclose an application completed by each "trainee."

(4) Trainees shall be eligible to take the adjuster's examination required by the insurance commissioner after completing six months in "trainee" status.

(5) No person shall be a "trainee" as defined herein for more than one nine-month period. A violation of this requirement or any provision of the insurance code shall subject both the trainee and their supervisory adjuster to penalties of the code.

[Statutory Authority: RCW 48.02.060. 90-04-060 (Order R 90-1), § 284-17-123, filed 2/2/90, effective 3/5/90.]

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.]

CONTINUING EDUCATION

WAC 284-17-200 Purpose. The purpose of this regulation is to implement the provisions of RCW 48.17.150, promoting licensee competence, by establishing the minimum continuing education requirements that must be met prior to the renewal of an insurance agent, solicitor or broker license, and by specifying minimum criteria which must be met in order to qualify insurance courses for approval.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-200, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-200, filed 3/20/80.]

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

(1) "Provider" means "insurance education provider" as defined in section 2, chapter 323, Laws of 1989.

(2) "Approved course" includes courses, programs of instructions, correspondence courses and seminars.

(3) "Licensee" means each natural person licensed as a resident insurance agent, solicitor or broker to sell life, disability, property, or casualty insurance. An individual holding a limited license to sell credit life and disability insurance, or travel insurance, or holding a license to sell only vehicle insurance or surety insurance, need not satisfy the continuing education requirement.

(4) "Credit hours" means the value assigned to a course by the commissioner, upon review and approval of course materials and content outline.

The number of credit hours assigned to a course will normally be based upon the number of classroom contact hours or their equivalent. However, based upon the evaluation of the course content, the number of credit hours assigned may be less than the total amount of time spent by the licensee in the course.

For college level work entirely on approved subjects:

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

(b) Sixteen credit hours will be assigned for each semester "credit hour."

(5) "Certificate of completion" means a document signed by the course instructor or other responsible officer of the provider signifying satisfactory completion of the course and reflecting credit hours earned. Such certificate shall be in standard form, completed in its entirety, and containing such identifying information as is prescribed by the insurance commissioner.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-210, filed 9/15/89, effective 10/16/89; 82-10-016 (Order R 82-2), § 284-17-210, filed 4/28/82. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-210, filed 3/20/80.]

WAC 284-17-220 Continuing education requirement. (1) Twenty-four credit hours of approved continuing education must be presented as a prerequisite to each license renewal or reinstatement.

(2) Effective July 1, 1996, the number of required continuing education credit hours will be increased from twenty-four to thirty-two hours for each two-year licensing period.

Each course credit applied toward satisfaction of the continuing education requirement must have been completed within the twenty-four month period immediately preceding the licensee's assigned license renewal date and the credit may not have been used previously to comply with the continuing education requirement.

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

(4) Repeating an approved course for which the licensee has previously claimed credit will not satisfy the continuing education requirement.

(5) The licensee must retain the certificate of completion for three years from the date on the certificate and must present the original of such certificate upon request of or audit by the commissioner.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-220, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-220, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-220, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-220, filed 3/20/80.]

WAC 284-17-230 Eligible courses—Advance approval required. (1) Courses eligible for approval to satisfy the continuing education requirement are those courses demonstrating a direct and specific application to insurance.

(1995 Ed.)

(a) General education courses and sales motivation courses shall not be eligible for approval.

(b) Courses shall present accurately all statutory and regulatory requirements then applicable or published by the code reviser at the time the course is offered.

(2) All courses must be approved prior to the beginning of study in order to be applied toward the satisfaction of the continuing education requirement.

(3) Approval of the course is valid for the provider that originally submitted the course to the commissioner, and is not transferable to any other entity.

(4) The commissioner shall assign an identifying certification number to each approved course. The certification number shall be listed on each certificate of completion issued by the provider.

(5) The provider shall issue a certificate of completion to each licensee who has satisfactorily completed the course, within fifteen days after completion or within fifteen days of the date the course was approved by the commissioner, whichever event is later.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-230, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-230, filed 3/20/80.]

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 284-17-240 Courses specifically approved.

(1) The following courses are approved as they exist on the date this regulation is adopted, for the credit hours stated:

(a) Any part of the life underwriter training council life course curriculum (50 hours credit) or health course curriculum (25 hours credit).

(b) Any part of the American College "CLU" diploma curriculum (30 hours credit), and its advanced study programs; Chartered Life Underwriter Institutes conducted by the American Society of CLU.

(c) Any part of the Insurance Institute of America's program of insurance (20 hours credit).

(d) Any part of the American Institute for Property and Liability Underwriter's Chartered Property Casualty Under-

writer (CPCU) professional designation program (30 hours credit).

(e) Any part of the certified insurance counselor program (25 hours credit).

(f) Insurance related courses taught by a college or university that is accredited by the Northwest Association of Schools and Colleges, for which credit is granted.

(2) Changes in the above identified courses shall be presumed to be approved by the commissioner unless the sponsoring organization is advised of disapproval.

(3) Programs for which credit hours are not shown shall receive such credit hours as are approved by the commissioner.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-240, filed 3/20/80.]

WAC 284-17-250 Courses conducted by self-certifying organizations. (1) Insurance companies, insurance trade associations and state-wide associations of agents or brokers that have an existing formal, and demonstrable, training program may become self-certifying organizations. Upon request to and approval by the commissioner, such self-certifying organizations are authorized to develop course content and conduct approved courses on the subjects that are the organization's focus, without the requirement for prior individual course review and approval by the commissioner.

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

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

(a) The name of the organization.

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

(i) The titles and descriptions of courses taught during the previous year.

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

(iii) The name of the person in charge of the training program and a description of her or his experience, including years of full-time training experience and years with past and present organizations.

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

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

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

(e) An agreement to provide a certificate of completion, showing credit hours earned, to each successful student.

(f) An agreement to maintain records of licensees' course completions for three years.

(g) Any catalogue, brochure, or other similar publication applying to the continuing education requirement.

(4) The grant of authority to an organization to develop course content and conduct courses without prior individual course approval shall be for a period of time not to exceed two years. Approvals may be renewed by the commissioner, upon the request of any self-certifying organization that has complied with statutes and regulations governing insurance education. The actual conduct and performance of the training program shall be subject to review by the commissioner.

(5) Organizations that have been authorized to develop course content and conduct courses without prior individual course approval shall file, within ten calendar days of the date any course is first presented, a course outline for each course with the commissioner. The course outline shall include:

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

(b) The method of teaching or presentation.

(c) The number of classroom contact hours.

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

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

(f) Other relevant information.

(6) The self-certifying organization shall apply to the commissioner for a certification number for the course; such number shall appear on each certificate of completion issued to each licensee who successfully completes the course.

(7) Assignment of continuing education credit hours to courses, by self-certifying organizations, shall be subject to review and revision by the commissioner as necessary to ensure consistency in the number of credit hours assigned to comparable courses.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-250, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-250, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-250, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-250, filed 3/20/80.]

WAC 284-17-260 Courses individually approved.

Organizations or individuals not included in WAC 284-17-240 or 284-17-250 wanting to offer approved continuing education courses may submit their request(s) for individual course approval to the commissioner.

(1) Such requests for course approval must be submitted on forms prescribed by the commissioner.

(2) The request for course approval shall include:

(a) A copy of the course material that is requested to be approved.

(b) An explanation of the method of teaching or presentation.

(c) The number of classroom contract hours.

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

(e) The number of continuing education credit hours for which approval is requested; and an estimate of the number of times the proposed course is to be offered.

(f) An agreement to provide a certificate of completion showing credits earned, to each successful licensee; and to retain, for a minimum period of three years, records of all certificates issued.

(g) An agreement by the responsible official to comply with regulations in conducting courses.

(3) A specific determination of course approval and assignment of credit hours will be made by the commissioner in accordance with the terms of WAC 284-17-230. No course for which individual course approval is required may be represented as being approved prior to actual approval. Approval of an individual course is valid for a maximum period of twenty-four months from the original approval date.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-260, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-260, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-260, filed 3/20/80.]

WAC 284-17-270 Credit for courses. (1) No course shall be established for less than one continuing education credit. Courses conducted in conjunction with other nonqualifying activities or subject matter must have a separate continuing education course component in order to qualify the courses for approval.

(2) The provider of a course must maintain a positive attendance record, consisting of a sign in - sign out register, in order to qualify the course for continuing education credit. The provider must retain such registers, or any other evidence of satisfactory completion, for a period of three years from the date of completion.

(3) The instructor of an approved course shall receive twice the number of credit hours for teaching a course as is earned by a licensee completing the course. Such instructor may not, however, claim continuing education credit for completing or teaching a course for which he or she has previously claimed credit.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-270, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-270, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-270, filed 3/20/80.]

WAC 284-17-275 Courses not approved. A course will not be approved if any requirement of this chapter is not met, or if the instructor lacks education or experience in the subject matter of the proposed course, or if the provider or any of its employees or contractors who are supervising or conducting, and certifying completion of an insurance course:

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

(2) Has had an insurance license revoked, suspended, or refused because of violations of or noncompliance with insurance statutes or regulations.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-275, filed 9/15/89, effective 10/16/89; 88-01-074 (Order R 87-12), § 284-17-275, filed 12/18/87, effective 3/1/88.]

WAC 284-17-280 Approved courses or self-certifying organizations—Loss of approval. (1) The approval of a course, or of a self-certifying organization, may be suspended or revoked if the commissioner determines that:

(a) The content of an individually approved course was significantly changed without notice to and approval from, the commissioner.

(b) A certificate of completion was issued to any individual who did not complete the course.

(c) A certificate of completion was not issued to any individual who satisfactorily completed the course.

(d) The actual instruction of the course is determined by the commissioner to be inadequate.

(e) In the commissioner's discretion, the course or courses offered by a self-certifying organization fail to meet the objectives and requirements of the statutes and regulations requiring continuing education for insurance agents and brokers.

(f) The provider failed to comply with the commissioner's request for submissions of updated descriptions of any course offerings; or records, course materials, or audit information were not provided within fifteen days of the commissioner's request.

(g) The provider, or any of its employees or contractors involved in insurance education, has violated insurance laws including, but not limited to the regulations contained in this chapter.

(2) If the commissioner finds under this chapter, that disciplinary action against any provider is appropriate, the commissioner may exercise the discretion to suspend or revoke all approvals of that provider's concurrent offerings, and refuse to approve submissions of previously approved courses.

(3) Reinstatement of a suspended or revoked approval shall be at the discretion of the commissioner after receipt of satisfactory proof that the conditions responsible for the suspension have been corrected.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-280, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-280, filed 3/20/80.]

WAC 284-17-290 Waiver of continuing education requirement. (1) Any licensee who believes that good cause exists, may request a waiver of the continuing education requirement. Requests shall be in writing, received prior to the expiration of the licensee's existing license and specify in substantive detail the reason or reasons why the licensee believes a waiver of the continuing education requirement for the current license renewal is merited.

(2) Any request for a waiver which is based upon the licensee's retirement shall be accompanied by a statement attesting that the licensee:

(a) Is at least sixty-five years of age;

(b) Is retired from active selling of insurance products; and

(c) No longer represents any insurer.

(3) If the conditions upon which a waiver was granted change, the licensee shall notify the commissioner in writing within fifteen days, and may be required to satisfy the continuing education credit hours which would have been prerequisite to license renewal had the waiver not been granted. Violation of the conditions of this waiver may result in assessment of a fine, revocation of license, or both.

(4) Any request for a waiver which is based upon medical considerations shall be accompanied by a physician's statement of the applicant's illness or injury.

(5) No waiver shall be valid for a period in excess of two years from the applicant's regular license renewal date.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-290, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-290, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-290, filed 3/20/80.]

WAC 284-17-300 Continuing education advisory committee. There is hereby created a continuing education advisory committee to be made up of five members appointed for staggered terms by the commissioner. The advisory committee shall, as requested by the commissioner, provide assistance and advice in the implementation of the continuing education regulation.

[Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-300, filed 3/20/80.]

WAC 284-17-310 When continuing education requirement must be met. (1) Each licensee, as defined in WAC 284-17-210(3), shall present evidence of completing the continuing education requirement, prior to license renewal or reinstatement.

(2) Such evidence shall include specific information on the approved course or courses the licensee completed to satisfy the continuing education requirement.

(3) Each credit applied to satisfy the continuing education requirement must have been earned, by completing the relevant course, before the licensee applies for renewal or reinstatement.

[Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-310, filed 9/15/89, effective 10/16/89; 82-10-016 (Order R 82-2), § 284-17-310, filed 4/28/82. Statutory Authority: RCW 48.02.060 and 48.17.150. 81-18-049 (Order R 81-5), § 284-17-310, filed 8/31/81. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-310, filed 3/20/80.]

WAC 284-17-320 License renewal requested—Continuing education requirement not satisfied. In the event that a licensee requests license renewal and fails to present evidence of completion of the continuing education requirement, the licensee shall be notified in writing of the deficiency and provided with fifteen calendar days from the renewal date or the date of notification, whichever is later, to show compliance. If the information necessary to renew the license is not received within the fifteen-day time period, the license shall lapse and become invalid. Application for renewal after that date, must be made according to the procedures of RCW 48.17.150 and 48.17.500.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-320, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 89-19-037 (Order R 89-10), § 284-17-320, filed 9/15/89, effective 10/16/89. Statutory Authority: RCW 48.17.150 as amended by 1979 ex.s. c 269 §§ 7,10. 80-04-042 (Order R 80-3), § 284-17-320, filed 3/20/80.]

RENEWALS, APPOINTMENTS AND AFFILIATIONS

WAC 284-17-400 Renewal dates for agents, brokers, solicitors and adjusters. New individual licenses, issued on or after July 1, 1994, will be valid for a period ending with the licensee's first birthday anniversary after the initial issue date, plus one year.

New firm or corporation licenses, issued on or after July 1, 1994, will be valid for a period of two years from the initial issue date.

Thereafter, such licenses will be renewed for a period of two years.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-400, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-400, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-400, filed 3/20/80.]

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

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

(3) Termination of an appointment by the agent may be accomplished by the agent giving advance written notice to the insurer with a copy mailed to the insurance commissioner that, as of a date stated in such notice, the agent renounces the appointment and will no longer represent the insurer as its agent.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-410, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-410, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-410, filed 3/20/80.]

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

(2) All firms or corporations licensed as an agent, adjuster or broker shall notify the office of the insurance commissioner of all persons who are empowered to exercise

the authority conferred by the firm or corporate license. For purposes of this section, such persons shall be defined as "affiliated" with the licensed firm or corporation.

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

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

(5) Termination of an appointment by an affiliated person may be accomplished by such person giving advance written notice to the firm or corporation with a copy mailed to the insurance commissioner that, as of a date stated in such notice, the affiliated person renounces the appointment and will no longer act on behalf of the firm or corporation.

[Statutory Authority: RCW 48.01.030, 48.02.060(3), 48.14.010, 48.17.150(2), 48.17.160 (1)(5) and 48.17.500(3). 94-14-033 (Order R 94-14), § 284-17-420, filed 6/28/94, effective 7/29/94. Statutory Authority: RCW 48.02.060. 84-19-022 (Order R 84-3), § 284-17-420, filed 9/12/84. Statutory Authority: RCW 48.02.060 and 1979 ex.s. c 269 § 10. 80-04-041 (Order R 80-4), § 284-17-420, filed 3/20/80.]

PRELICENSE EDUCATION

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, educational institution created by Washington statutes or vocational school licensed under Title 28C RCW, or independent contractor, to which the commissioner has granted authority to conduct and certify completion of an approved course satisfying the insurance education requirements of RCW 48.17.150.

(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 the applicable section(s) 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 presented under the supervision of an approved instructor, according to the applicable section of either WAC 284-17-540 or 284-17-545.

(3)(a) "Instructor" means a person meeting the requirements of WAC 284-17-537.

(b) "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. 89-14-045 (Order R 89-8), § 284-17-505, filed 6/29/89. 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 or licensed experience that meets or exceeds the requirements of subsections (1) or (2) of this section as applicable, may file a written petition with the commissioner for a waiver of the prelicense education 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 in accordance with provisions of subsection (3) of this section.

(1) **Equivalent education.** 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 pre-

scribed 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) **Licensed experience.** A written waiver from the prelicense education requirement for life, disability, casualty, or property insurance as defined respectively by WAC 284-17-552, 284-17-553, 284-17-554, or 284-17-555 may be granted by the commissioner to any person who can demonstrate that (a) he or she has been licensed within the previous ninety days for the same line or lines of insurance in another state and that (b) he or she was licensed continuously for at least two years. Such waiver is not a waiver of Washington's statutes and regulations curriculum as defined in WAC 284-17-551.

(3) **Unavailability.** 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. 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 48.17.150. 91-12-032 (Order R 91-2), § 284-17-515, filed 6/3/91, effective 7/4/91. 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 November 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. 89-14-045 (Order R 89-8), § 284-17-520, filed 6/29/89. 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) and (ii) 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; or to program directors employed by vocational-technical institutes governed by the superintendent of public instruction and the state board of education.

(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 interim 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. 89-19-036 (Order R 89-9), § 284-17-535, filed 9/15/89, effective 10/16/89; 89-14-045 (Order R 89-8), § 284-17-535, filed 6/29/89. 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 experience instructing insurance education courses, supervising students completing self-paced insurance instructional materials, or 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 on the premises whenever instruction is being offered.

(c) Ensure that the study materials utilized, incorporate the prescribed curriculum, and comply with the lesson plans filed with the commissioner.

(d) The instructor may teach approved courses on a live-instruction basis, or combine live instruction with the use of other instructional aids, or proctor student use of self-paced insurance instructional materials.

(e) 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.

(f) 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.

(g) Review course evaluations with the program director.

[Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-537, filed 6/29/89. 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 the 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.

(a) After November 1, 1994, the license(s) must have been held in good standing for at least five years.

(b) The requirements of this subsection shall not apply to program directors employed by community colleges

governed by chapters 28B.19 and 28B.50 RCW, or to program directors employed by vocational-technical institutes governed by the superintendent of public instruction and the state board of education.

(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 or experience supervising student completion of self-paced instructional materials, the combination to total a minimum of three consecutive years' qualifications. After November 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.

[Statutory Authority: RCW 48.02.060. 89-19-036 (Order R 89-9), § 284-17-540, filed 9/15/89, effective 10/16/89; 89-14-045 (Order R 89-8), § 284-17-540, filed 6/29/89. 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 designa-

tions 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. These line specific statutes and regulations are not to be contained in the statutes and regulations curriculum of general application found at WAC 284-17-551.

(2) To qualify for approval, each course shall be presented under the supervision of an approved instructor, utilizing study materials that include all the prescribed curriculum, and shall be presented under the general 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 on the premises whenever instruction is being offered.

(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 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. 89-14-045 (Order R 89-8), § 284-17-550, filed 6/29/89. 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) Insurer;
 - (c) Public interest;
 - (d) Risk management;
 - (e) Law of large numbers;
 - (f) Indemnification.
- (2) Insurance commissioner:
 - (a) Authority and duties;
 - (b) Broad powers;
 - (c) Rate and form filings;
 - (d) Examination of records;
 - (e) Penalties;
 - (f) Notice of hearing;
 - (g) Examinations:
 - (i) Insurers' financial status;
 - (ii) License applicant's qualifications.
 - (h) Hearings and appeals;
 - (i) 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) Exemptions;
 - (ii) Limited lines;
 - (iii) Temporary;
 - (iv) Nonresident;
 - (v) Authority and liability under the regulation:
 - (A) Solicitor;
 - (B) Agent;

- (C) Broker;
- (D) Surplus lines broker;
- (E) Adjuster: Independent, public.
- (6) Major lines:
 - (a) Life insurance;
 - (b) Disability insurance;
 - (c) Property insurance;
 - (d) Casualty insurance.
- (7) Other lines:
 - (a) Vehicle insurance;
 - (b) Surety;
 - (c) Credit life and credit accident/health;
 - (d) Travel insurance.
- (8) Penalties for noncompliance:
 - (a) Refusal/nonrenewal;
 - (b) Suspension/revocation;
 - (c) Fines;
- (9) Maintenance and duration of license:
 - (a) Appointments/terminations of appointments;
 - (b) Renewal procedures;
- (10) Licensing requirements:
 - (a) Purpose;
 - (b) Licensing procedures:
 - (i) Resident;
 - (ii) Nonresident.
 - (iii) Temporary license.
 - (c) Continuing education; renewal procedures:
 - (i) Penalties for misconduct;
 - (ii) Exemption from the licensing requirement.
 - (iii) Temporary license.
- (11) Agent responsibilities:
 - (a) Recordkeeping;
 - (b) Reply promptly to inquiry by the commissioner; notify the commissioner of a change of address;
 - (c) Application completion;
 - (d) Policy delivery;
 - (e) Separate account requirement;
 - (f) Premium accountability;
 - (g) Fiduciary accountability.
- (12) Compensation of licensees:
 - (a) Sharing commissions;
 - (b) Charges for extra services.
- (13) Protection of public interest.
- (14) Unfair practices:
 - (a) Advertising, comparisons, and defamation;
 - (b) Charges, inducements, rebating;
 - (c) Misrepresentation;
 - (d) Twisting;
 - (e) Illegal dealing in premiums;
 - (f) Illegal inducements;
 - (g) Failure to issue proper receipts;
 - (h) Unfair claims methods and trade practices;
 - (i) Broker's fees disclosed;
 - (j) Penalties;
 - (k) Discrimination.
- (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 of individual life insurance:
 - (a) Term insurance policies:
 - (i) General nature;
 - (ii) Basic types of term contracts;
 - (iii) Special features;
 - (iv) Level, decreasing or increasing benefit.
 - (A) Renewability;
 - (B) Convertibility;
 - (C) Reentry.
 - (b) Whole life insurance:
 - (i) General nature;
 - (ii) Economic values of whole life;
 - (c) Basic types of whole life contracts:
 - (i) Straight (ordinary) life;
 - (ii) Limited pay life;
 - (iii) Endowment insurance.
 - (d) Universal life:
 - (i) General nature;
 - (ii) Features and characteristics;
 - (iii) Fixed versus variable.
 - (e) Single premium whole life:
 - (i) Fixed;
 - (ii) Variable.
 - (3) Premium variations:
 - (a) Single;
 - (b) Level;
 - (c) Adjustable;
 - (d) Modified;
 - (e) Graded.
 - (4) Annuities:
 - (a) The annuity principle;
 - (b) Nature and purpose;
 - (c) Premium-payment method:
 - (i) Single;
 - (ii) Fixed installment;
 - (iii) Flexible.
 - (d) Tax-qualified plans; nonqualified plans;
 - (e) Fixed versus variable benefits;
 - (f) When benefits begin;
 - (g) Number of lives covered;
 - (h) Payout options:
 - (i) Period certain;
 - (ii) Interest only;
 - (iii) Fixed/variable.
 - (i) Guarantee prior to annuity starting date;
 - (j) Guarantee of minimum total benefit:
 - (i) Straight (pure) life annuity;
 - (ii) Annuity with period certain;

[Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-551, filed 6/3/91, effective 7/4/91. 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:

- (iii) Cash or installment refund annuity.
- (5) Other life insurance products:
 - (a) Keogh (HR-10) plan;
 - (b) Individual retirement account (IRA);
 - (c) Simplified employee pension plan (SEP);
 - (d) Key person;
 - (e) Buy-sell;
 - (f) Executive bonus;
 - (g) Split dollar;
 - (h) Tax sheltered annuity.
- (6) Group life insurance:
 - (a) Types of contracts:
 - (i) Term, including survivorship;
 - (ii) Contracts with permanent benefits;
 - (iii) Credit or mortgage life.
 - (b) Group underwriting principles;
 - (c) Master policy and certificates;
 - (d) Conversion rights and limitations.
- (7) Combination policies and variations in basic forms:
 - (a) Double or triple indemnity;
 - (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) Joint life;
 - (i) Last survivor;
 - (j) Juvenile;
 - (k) Adjustable life;
 - (l) Variable life.
- (8) Policy provisions, options, and other features:
 - (a) General provisions and clauses;
 - (i) Insuring agreement/consideration;
 - (ii) Owner/applicant/insured;
 - (iii) Assignment;
 - (iv) Entire contract;
 - (v) Incontestability;
 - (vi) Grace period/reinstatement;
 - (vii) Misstatement of age or sex;
 - (viii) Suicide;
 - (ix) War;
 - (x) Aviation;
 - (xi) Free look;
 - (xii) Representations;
 - (xiii) Uniform Simultaneous Death Act;
 - (xiv) Settlement on proof of death;
 - (xv) Morbidity and mortality tables;
 - (xvi) Age, health, marital status, occupation;
 - (xvii) Loan provisions: Nature, interest, automatic premium loan.
 - (9) 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.
 - (10) Policy riders:
 - (a) Policy loan provision;
 - (b) Automatic premium loan;
- (c) Waiver of premium;
- (d) Guaranteed insurability;
- (e) Dividends/excess interest declarations;
- (f) Nonforfeiture values, annuity tables;
- (g) Accidental death/dismemberment;
- (h) Disability income rider;
- (i) Cost of living rider.
- (11) Beneficiary designations:
 - (a) Estate/named party/class;
 - (b) Primary/contingent;
 - (c) Revocable/irrevocable;
 - (d) Trust.
 - (e) Common disaster, short-term survivorship; Uniform Simultaneous Death Act;
 - (f) Minor as beneficiary;
 - (g) Changing the beneficiary.
- (12) Application process:
 - (a) Application completion;
 - (b) Application as part of contract;
 - (c) Fair Credit Reporting Act compliance;
 - (d) Receipts;
 - (e) Modified/issued as requested;
 - (f) Nonprepaid/prepaid;
 - (g) Modes of payment/effect of nonpayment;
 - (h) Good health upon delivery;
 - (i) Ten-day free look.
- (13) 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;
 - (ii) Owner's rights;
 - (iii) Beneficiary's rights.
 - (e) Types of settlements:
 - (i) Lump sum;
 - (ii) Interest only;
 - (iii) Period certain, fixed amount.
- (14) Federal taxation:
 - (a) Life insurance premiums;
 - (b) Proceeds;
 - (c) Dividends:
 - (i) Nature of dividends;
 - (ii) Four basic options for the use of dividends;
 - (iii) One-year term (fifth) dividend option.
 - (d) Policy loans/withdrawals.
- (15) Other topics:
 - (a) Social Security survivors, death, and retirement benefits;
 - (b) Legal concepts:
 - (i) Insurable interest;
 - (ii) Misrepresentation and concealment;
 - (c) Evaluation of life insurance needs:
 - (i) Needs approach;
 - (ii) Human life value approach.
 - (d) Cost comparison methods;
 - (i) Interest-adjusted cost;
 - (ii) Traditional net cost.
 - (e) Credit life.
 - (f) Business uses of life insurance:
 - (i) Buy and sell agreements;
 - (ii) Cross-purchase plan;

- (iii) Entity plan.
- (g) Key person insurance.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-552, filed 6/3/91, effective 7/4/91. 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) Insuring agreement and perils covered;
 - (d) Definition of total disability:
 - (i) Own occupation;
 - (ii) Any occupation for which the insured is reasonably suited;
 - (iii) Any occupation;
 - (iv) Combination definitions;
 - (v) Presumptive disability.
 - (e) Temporary disability;
 - (f) Permanent disability:
 - (i) Partial;
 - (ii) Total;
 - (g) Residual disability;
 - (h) Recurrent disability;
- (2) Underwriting considerations:
 - (a) Elimination (waiting) period;
 - (b) Probationary period;
 - (c) Benefit period:
 - (i) Short-term versus long-term;
 - (ii) Accident versus sickness;
 - (d) Nonoccupational versus full coverage;
 - (e) 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;
 - (v) Illegal occupation;
 - (f) Rating standards:
 - (i) Reasonable, equitable, adequate;
 - (ii) Class exposures to a degree of risk;
 - (g) Common exclusions;
- (3) Accidental death/dismemberment;
- (4) Needs analysis: Human life value, economic value;
- (5) Disability insurance policy provisions:
 - (a) Mandatory individual policy provisions:
 - (i) Grace period;
 - (ii) Reinstatement;
 - (iii) Misstatement of age or sex;
 - (iv) Change of beneficiary;
 - (v) Entire contract;
 - (vi) Time limit on certain defenses;
 - (vii) Notice of claim;
 - (viii) Claim forms;
 - (ix) Proof of loss;
 - (x) Time of payment of claims;
 - (xi) Payment of claims;
 - (xii) Physical examination and autopsy;
 - (xiii) Legal actions.
 - (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.
- (vii) Chemical dependency;
- (viii) Relation of earnings to insurance;
- (ix) Unpaid premiums;
- (x) Cancellation;
- (xi) Conformity with state statute;
- (6) Other provisions:
 - (a) Consideration/premium payment;
 - (b) Modes of payment;
 - (c) Effect of nonpayment;
 - (d) Claims control;
 - (i) Second surgical opinion;
 - (ii) Precertification;
 - (iii) Ambulatory treatment.
 - (e) Conversion;
 - (f) Waiver of premium;
 - (g) Assignment;
 - (h) Preexisting conditions;
 - (i) Right to examine;
 - (j) Policy continuation:
 - (i) Cancellable;
 - (ii) Optionally renewable;
 - (iii) Conditionally renewable;
 - (iv) Guaranteed renewable;
 - (v) Noncancellable.
- (7) Benefit features, options:
 - (a) Cost of living adjustment;
 - (b) Accident medical expense;
 - (c) Guaranteed insurability option;
 - (d) Accidental death and dismemberment;
 - (e) Social Security rider;
 - (f) Lifetime/extended benefit;
 - (g) Assignment of benefits;
 - (h) Benefit periods:
 - (i) Long term/short term;
 - (ii) Illness/injury.
 - (i) Nonduplication of benefits:
 - (i) Other insurers;
 - (ii) Benefit maximum.
 - (j) Special policy provisions:
 - (i) Disability buy-out;
 - (ii) Lump sum;
 - (iii) Periodic payment;
 - (k) Specified injury or illness.
- (8) Disability benefits in life insurance contracts.
- (9) Business overhead expense coverage.
- (10) Hospital income coverage.
- (11) Credit protection/mortgage protection.
- (12) Sources of medical (accident and health) benefits:
 - (a) Insurance companies;
 - (b) Health care service contractors (HCSC);
 - (c) Health maintenance organizations (HMO);
 - (d) Preferred provider organizations (PPO);
 - (e) Health Insurance Coverage Access Act:
 - (i) Nature and purpose;
 - (ii) Eligibility;
 - (iii) Coverage available.

- (13) Basic medical expense insurance:
- (a) Nature and purpose;
 - (b) Insuring agreements and perils covered;
 - (c) Hospitalization expense;
 - (i) Room and board;
 - (ii) Intensive care;
 - (iii) Ancillary (miscellaneous) charges.
 - (d) Surgical expense:
 - (i) Schedules: Absolute value versus relative value;
 - (ii) Usual and customary.
 - (e) Regular medical expense (other physician charges):
 - (i) Charges covered;
 - (ii) Common limitations on benefits.
 - (f) Common exclusions.
 - (g) Other benefit features, options, or expense coverages:
- (i) Maternity;
 - (ii) Private duty nursing;
 - (iii) Dental;
 - (iv) Prescription drug;
 - (v) Vision;
 - (vi) Home health care;
 - (vii) Dread disease and limited (e.g., cancer) coverage.
- (14) Major medical expense insurance:
- (a) Nature and purpose;
 - (b) Covered charges (expenses);
 - (c) Inside (internal) limits;
 - (d) Waiting period, preexisting/named conditions;
 - (e) 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.
 - (f) Deductible:
 - (i) Per injury or sickness versus cumulative (e.g., annual);
 - (ii) Corridor;
 - (iii) Common accident/common sickness;
 - (iv) Family maximum;
 - (v) Basic or other plan benefits;
 - (vi) Carryover provision;
 - (vii) Coinsurance, copayment, stop loss;
 - (viii) Waiting periods;
 - (ix) Standards for coordination of benefits/nonduplication of benefits;
 - (x) Maximum limits:
 - (A) Per injury or illness versus lifetime;
 - (B) Unlimited;
 - (C) Restoration of used benefits.
 - (15) Comprehensive coverage:
 - (a) Basic plan plus major medical;
 - (b) Comprehensive major medical.
 - (16) Group insurance and related coverages:
 - (a) Types of benefits;
 - (b) Group underwriting considerations;
 - (c) Group enrollment restrictions:
 - (i) Age of applicant;
 - (ii) Coverage for dependents;
 - (iii) Time period for enrollment;
 - (iv) Preexisting condition.
 - (d) Master policy and certificates;
 - (e) Conversion;
 - (f) Probationary employment period;
 - (g) Extended benefits;
 - (h) Mandatory benefits and options;
 - (i) Nonduplication and coordination of benefits provision;
 - (j) Approaches related to group insurance:
 - (i) Franchise coverage;
 - (ii) Blanket coverage.
 - (k) Consolidated Omnibus Budget Reconciliation Act (COBRA).
 - (17) Government entitlement programs.
 - (18) Medicare:
 - (a) Eligibility and enrollment;
 - (b) Part A (Hospital);
 - (i) Hospital coverage:
 - (A) Benefits;
 - (B) Diagnostic related groups (DRG's).
 - (ii) Skilled nursing facilities;
 - (iii) Home health care;
 - (iv) Hospice care.
 - (c) Part B (Medical):
 - Medical coverage:
 - (i) Premium requirement;
 - (ii) Benefits;
 - (iii) Deductibles;
 - (iv) Coinsurance;
 - (v) Assignment;
 - (vi) Allowable charges versus usual and customary.
 - (d) Definitions:
 - (i) Carrier;
 - (ii) Intermediary;
 - (iii) Spell of illness;
 - (iv) Coverage outside the United States.
 - (19) Medicare supplements:
 - (a) Nature and purpose;
 - (b) Minimum standards;
 - (c) Preexisting conditions;
 - (d) Disclosure;
 - (e) Renewability;
 - (f) Replacement.
 - (20) Social Security disability and medical expense benefits.
 - (21) Long-term care:
 - (a) Nature and purpose;
 - (b) Policies and contracts;
 - (c) Skilled/intermediate care;
 - (d) Disclosure;
 - (e) Free look;
 - (f) Prohibited practices.
 - (22) 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;
- (f) Application completion;
- (g) Fair Credit Reporting Act compliance.
- (23) 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 service coverage carriers:
 - (i) Standards for group chemical dependency coverage;
 - (ii) Rules pertaining to AIDS;
 - (iii) Health Care False Claim Act;
 - (c) Misrepresentation and concealment.
 - (24) 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.
 - (25) Other topics:
 - (a) Accidental death and dismemberment coverage:
 - (i) Insuring agreements and perils covered;
 - (ii) Principle (capital) sum;
 - (iii) Beneficiary designations.
 - (b) Business uses: The disability buy-out.
 - (26) Federal income taxation:
 - (a) Disability insurance premium;
 - (b) Disability insurance benefits.
- (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:
 - (i) Entire contract;
 - (ii) Agency binding authority;
 - (iii) Rating and premium determination.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 91-12-033 (Order R 91-3), § 284-17-553, filed 6/3/91, effective 7/4/91. 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;

(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:
 - Mobile home owner.
 - (g) Miscellaneous personal casualty coverages:
 - (i) Umbrella;
 - (ii) Excess auto liability;
 - (iii) Recreational vehicles;
 - (iv) Watercraft/yacht.
 - (h) Incidental farming.
- (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;
 - (viii) Liquor liability.

(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) Fire 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 burglary;
 - (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) Forgery;
 - (e) Employee Retirement Income Security Act (ERISA);
 - (f) 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 48.17.150. 91-12-033 (Order R 91-3), § 284-17-554, filed 6/3/91, effective 7/4/91. 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;
 - (iii) Concurrent causation.
 - (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.
 - (A) Entire contract;
 - (B) Agency binding authority.
 - (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:
 - Mobile home.
 - (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;
- (vii) Farmowner's.
- (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 48.17.150. 91-12-033 (Order R 91-3), § 284-17-555, filed 6/3/91, effective 7/4/91. 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 precense 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 November 1, 1989, must submit a request for provider approval to the commissioner before August 1, 1989.

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

[Statutory Authority: RCW 48.02.060. 89-14-045 (Order R 89-8), § 284-17-570, filed 6/29/89. Statutory Authority: RCW 48.02.060 and 48.17.070. 89-01-055 (Order R 88-14), § 284-17-570, filed 12/16/88.]

MISCELLANEOUS REQUIREMENTS

WAC 284-17-600 Licensing requirements for licensees who maintain more than one place of business in the state. (1) If an agent operates out of more than one place of business in this state, in addition to complying with the requirements of RCW 48.17.450, each such location must be under the charge of an individual properly licensed for the insurance transactions being conducted at the location, and such individual must be physically present in such location during the times such location is open for the transaction of insurance, to the same extent as would be expected of an agent operating at a single location. Each agent involved in an insurance transaction must have the appointments necessary for each such transaction, whether by direct appointment from the insurer or by affiliation with an appropriately appointed agent.

(2) If an insurance agent is also licensed as an insurance broker while maintaining more than one place of business in this state, transactions in any location which require the services of a broker shall be conducted only by a properly licensed broker.

(3) A failure to comply with this section shall be an unfair practice pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.17.530 and 48.05.140.

(4) As contemplated by RCW 48.01.060, the transaction of insurance includes solicitation, negotiations preliminary to execution, execution of an insurance contract, transaction of matters subsequent to execution of the contract and arising out of it, and insuring.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.05.140(9), 48.17.060, 48.17.180, 48.17.530 and 48.30.010. 90-22-039 (Order R 90-12), § 284-17-600, filed 11/1/90, effective 1/15/91.]

Chapter 284-18 WAC

WASHINGTON INSURANCE HOLDING COMPANY REGULATION

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-18-010	Title and purpose. [Order R-71-2, § 284-18-010, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-020	Definitions. [Order R-71-2, § 284-18-020, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-030	Control acquisition of domestic insurer. [Order R-71-2, § 284-18-030, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-040	Registration of insurers. [Order R-71-2, § 284-18-040, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-050	Alternative and consolidated registrations. [Order R-71-2, § 284-18-050, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-060	Exemptions. [Order R-71-2, § 284-18-060, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-070	Disclaimers and termination of registration. [Order R-71-2, § 284-18-070, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-080	Extraordinary dividends and other distributions. [Order R-71-2, § 284-18-080, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
284-18-090	Additional information may be required. [Order R-71-2, § 284-18-090, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.

- 284-18-100 Forms. [Order R-71-2, § 284-18-100, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
- 284-18-110 Instructions for use of Forms A and B. [Order R-71-2, § 284-18-110, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
- 284-18-120 Effective date. [Order R-71-2, § 284-18-120, filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
- 284-18-990 Form A—Statement regarding the acquisition of control of or merger with a domestic insurer. [Form A is a part of Order R-71-2 (codified as WAC 284-18-990), filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.
- 284-18-99001 Form B—Insurance holding company system registration statement. [Form B is a part of Order R-71-2 (codified as WAC 284-18-99001), filed 7/9/71, effective 8/10/71.] Repealed by 93-19-005 (Order R 93-9), filed 9/1/93, effective 10/2/93. Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9.

WAC 284-18-300 Forms—General requirements.

(1) Forms A, B, C, and D are intended to be guides in the preparation of the statements required by sections 4, 6, and 7, chapter 462, Laws of 1993. They are not intended to be blank forms which are to be filled in. These statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(2) Two complete copies of Form A, and one copy of Forms B, C, and D, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of Washington, Insurance Building, Post Office Box 40255, Olympia, Washington 98504-0255, Attention: Company Supervision. One complete copy of Form A shall also be filed with the commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of Washington, Seattle, Washington 98104, Attention: Chief Examiner. A copy of Form C shall be filed in each state in which an insurer is authorized to do business, if the commissioner of that state has notified the insurer of its request in writing, in which case the insurer has ten days from receipt of the notice to file such form. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(3) Statements should be prepared on paper 8 1/2" x 11" (or 8 1/2" x 14") in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable, and

suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-300, filed 9/1/93, effective 10/2/93.]

WAC 284-18-310 Forms—Incorporation by reference, summaries, and omissions. (1) Information required by any item of Form A, Form B, or Form D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the commissioner which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear, or confusing.

(2) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the commissioner which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-310, filed 9/1/93, effective 10/2/93.]

WAC 284-18-320 Forms—Information unknown or unavailable and extension of time to furnish. (1) Information required need be given only insofar as it is known or reasonably available to the person filing the statement. If any required information is unknown and not reasonably available to the person filing, either because the obtaining thereof would involve unreasonable effort or expense, or because it rests peculiarly within the knowledge of another person not affiliated with the person filing, the information may be omitted, subject to the following conditions:

(a) The person filing shall give such information on the subject as it possesses or can acquire without unreasonable effort or expense, together with the sources thereof; and

(b) The person filing shall include a statement either showing that unreasonable effort or expense would be involved or indicating the absence of any affiliation with the person within whose knowledge the information rests and stating the result of a request made to such person for the information.

(2) If it is impractical to furnish any required information, document, or report at the time it is required to be filed, there may be filed with the commissioner a separate document:

(a) Identifying the information, document, or report in question;

(b) Stating why the filing thereof at the time required is impractical; and

(c) Requesting an extension of time for filing the information, document, or report to a specified date. The request for extension shall be deemed granted unless the commissioner within sixty days after receipt thereof enters an order denying the request.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-320, filed 9/1/93, effective 10/2/93.]

WAC 284-18-330 Forms—Additional information and exhibits. In addition to the information expressly required to be included in Form A, Form B, Form C, and Form D, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, or D shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change and not the date of the original filing.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-330, filed 9/1/93, effective 10/2/93.]

WAC 284-18-340 Definitions. (1) "The act" means the Insurer Holding Company Act, sections 1 through 15, chapter 462, Laws of 1993.

(2) "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

(3) "Foreign insurer" shall include an alien insurer except where clearly noted otherwise.

(4) "Ultimate controlling person" means that person which is not controlled by any other person.

(5) Unless the context otherwise requires, other terms found in these regulations and in section 2, chapter 462, Laws of 1993, are used as defined in that section 2, chapter 462, Laws of 1993. Other nomenclature or terminology is according to Title 48 RCW, or industry usage if not defined by Title 48 RCW.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-340, filed 9/1/93, effective 10/2/93.]

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WAC 284-18-350 Subsidiaries of domestic insurers. The authority to invest in subsidiaries under the act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of Title 48 RCW.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-350, filed 9/1/93, effective 10/2/93.]

WAC 284-18-360 Acquisition of control—Statement filing. A person required to file a statement pursuant to section 4, chapter 462, Laws of 1993, shall furnish the required information on Form A, hereby made a part of this regulation.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-360, filed 9/1/93, effective 10/2/93.]

WAC 284-18-370 Amendments to Form A. The applicant shall promptly advise the commissioner of any changes in the information so furnished on Form A arising subsequent to the date upon which such information was furnished but prior to the commissioner's disposition of the application.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-370, filed 9/1/93, effective 10/2/93.]

WAC 284-18-380 Acquisition of section 4(1), chapter 462, Laws of 1993, insurers. (1) If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of the second paragraph of section 4(1), chapter 462, Laws of 1993, the name of the domestic insurer on the cover page should be indicated as follows:

"ABC Insurance Company, a subsidiary of XYZ Holding Company."

(2) Where such an insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-380, filed 9/1/93, effective 10/2/93.]

WAC 284-18-390 Annual registration of insurers—Statement filing. An insurer required to file an annual registration statement pursuant to section 6, chapter 462, Laws of 1993, shall furnish the required information on Form B, hereby made a part of these regulations.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-390, filed 9/1/93, effective 10/2/93.]

WAC 284-18-400 Summary of registration—Statement filing. An insurer required to file an annual registration statement pursuant to section 6, chapter 462, Laws of 1993, is also required to furnish information required on Form C, hereby made a part of this regulation. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the commissioner of that state.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-400, filed 9/1/93, effective 10/2/93.]

WAC 284-18-410 Amendments to Form B. (1) An amendment to Form B shall be filed within fifteen days after

the end of any month in which there is a material change to the information provided in the annual registration statement.

(2) Amendments shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the change and not the date of the original filings.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-410, filed 9/1/93, effective 10/2/93.]

WAC 284-18-420 Alternative and consolidated registrations. (1) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under section 6, chapter 462, Laws of 1993. A registration statement may include information not required by the act regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its state of domicile, provided:

(a) The statement or report contains substantially similar information required to be furnished on Form B; and

(b) The filing insurer is the principal insurance company in the insurance holding company system.

(2) The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

(3) With the prior approval of the commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under subsection (1) of this section.

(4) Any insurer may take advantage of the provisions of section 6 (8) or (9), chapter 462, Laws of 1993, without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if he or she deems such filings necessary in the interest of clarity, ease of administration, or the public good.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-420, filed 9/1/93, effective 10/2/93.]

WAC 284-18-430 Disclaimers and termination of registration. (1) A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

(a) The number of authorized, issued, and outstanding voting securities of the subject;

(b) With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number

of such shares concerning which there is a right to acquire, directly or indirectly;

(c) All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

(d) A statement explaining why such person should not be considered to control the subject.

(2) A request for termination of registration shall be deemed to have been granted unless the commissioner, within thirty days after he or she receives the request, notifies the registrant otherwise.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-430, filed 9/1/93, effective 10/2/93.]

WAC 284-18-440 Transactions subject to prior notice—Notice filing. An insurer required to give notice of a proposed transaction pursuant to section 7, chapter 462, Laws of 1993, shall furnish the required information on Form D, hereby made a part of these regulations.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-440, filed 9/1/93, effective 10/2/93.]

WAC 284-18-450 Extraordinary dividends and other distributions. (1) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

(a) The amount of the proposed dividend;

(b) The date established for payment of the dividend;

(c) A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

(d) A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

(i) The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurers own securities) paid within the period of twelve consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(ii) Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

(iii) If the insurer is a life insurer, the net gain from operations for the twelve-month period ending the 31st day of December next preceding;

(iv) If the insurer is not a life insurer, the net income for the twelve-month period ending the 31st day of December next preceding.

(e) A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

(f) A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

(2) Each registered insurer shall report to the commissioner all other dividends and other distributions to shareholders within five business days following the declaration thereof, and at least fifteen business days before payment, including the same information required by subsection (1)(a) and (d)(i) through (v) of this section.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-450, filed 9/1/93, effective 10/2/93.]

WAC 284-18-460 Adequacy of surplus. The factors set forth in section 7(3), chapter 462, Laws of 1993, are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The commissioner, instead, will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-460, filed 9/1/93, effective 10/2/93.]

WAC 284-18-910 Form A.

FORM A
STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC
INSURER

Name of Domestic Insurer

BY

Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

(State of domicile of insurer being acquired)

Dated: _____, 19__

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof

shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than one-half of one percent of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of ten percent or more of the voting securities of the applicant if the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose

of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he or she must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the twelve calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon

interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the twelve calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the annual statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or WAC 284-18-300 or 284-18-320.

Item 13. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of section 4, chapter 462, Laws of 1993 _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19__.

(SEAL) _____
Name of Applicant
BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19____, for and on behalf of (Name of Applicant); that (s)he is the (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____
(Type or print name beneath) _____

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-910, filed 9/1/93, effective 10/2/93.]

WAC 284-18-920 Form B.

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By

Name of Registrant

On Behalf of Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 19__

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the method(s) by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are equal to less than one-half of one percent of the total assets of the ultimate controlling person within the insurance holding company system unless it has assets valued at or exceeding ten million dollars. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system furnish the following information:

- (a) Name.
- (b) Home office address.
- (c) Principal executive office address.
- (d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.
- (e) The principal business of the person.
- (f) The name and address of any person who holds or owns ten percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

Furnish the following information for the directors and executive officers of the ultimate controlling person: The individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

- (a) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates;
- (b) Purchases, sales or exchanges of assets;
- (c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business;

(e) All management agreements, service contracts and all cost-sharing arrangements;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders;

(h) Consolidated tax allocation agreements; and

(i) Any pledge of the registrant's stock or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of section 6, chapter 462, Laws of 1993.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent or less of the registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material. (Note: Commissioner may by rule, regulation, or order provide otherwise.)

The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: The nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the annual statement of such insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or WAC 284-18-300 and 284-18-320.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of section 6, chapter 462, Laws of 1993, the registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19__.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 19__, for and on behalf of (Name of Company); that (s)he is the (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-920, filed 9/1/93, effective 10/2/93.]

WAC 284-18-930 Form C.

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By _____

Name of Registrant

On Behalf of Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 19__

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities

held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of ten percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: An individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of section 6, chapter 462, Laws of 1993, the registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19__.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached summary of registration statement dated _____, 19__, for and on behalf of (Name of Company); that (s)he is the (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-930, filed 9/1/93, effective 10/2/93.]

WAC 284-18-940 Form D.

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of —

By

Name of Registrant

On Behalf of Following Insurance Companies

Name Address

Blank lines for insurance company names and addresses.

Date: _____, 19__

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

Blank lines for individual contact information.

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

- (a) Name.
(b) Home office address.
(c) Principal executive office address.
(d) The organizational structure, i.e., corporation, partnership, individual, trust, etc.
(e) A description of the nature of the parties' business operations.
(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice...
(g) Where the transaction is with a nonaffiliate, the name(s) of the affiliate(s) which will receive...

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

- (a) A statement as to whether notice is being given under section 7 (1)(b)(i), (ii), (iii), (iv), or (v), chapter 462, Laws of 1993.
(b) A statement of the nature of the transaction.
(c) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES, OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than, (a) in the case of nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders or, (b) in the case of life insurers, three percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets, or make investments in any affiliate. Describe the amount and source of funds, securities, property, or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders or, with respect to life insurers, three percent of the

insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by section 7 (1)(b)(iii), chapter 462, Laws of 1993, furnish a description of the known or estimated amount of liability to be ceded or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and nonaffiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than five percent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS, AND COST-SHARING ARRANGEMENTS.

For management and service agreements, furnish:

- (a) A brief description of the managerial responsibilities, or services to be performed.
(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

- (a) A brief description of the purpose of the agreement.
(b) A description of the period of time during which the agreement is to be in effect.
(c) A brief description of each party's expenses or costs covered by the agreement.
(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of section 7, chapter 462, Laws of 1993, _____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the ____ day of _____, 19__.

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 19__, for and on behalf of (Name of Applicant); that (s)he is the (Title of Officer) of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

[Statutory Authority: RCW 48.02.060 and 1993 c 462 § 9. 93-19-005 (Order R 93-9), § 284-18-940, filed 9/1/93, effective 10/2/93.]

Chapter 284-19 WAC

WASHINGTON ESSENTIAL PROPERTY INSURANCE INSPECTION AND PLACEMENT PROGRAM

WAC

Table with 2 columns: WAC number and Title. Includes entries for 284-19-010 through 284-19-180.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

Table with 2 columns: WAC number and Disposition text. Includes entry for 284-19-200.

WAC 284-19-010 Title. These rules and regulations shall be entitled the Washington essential property insurance inspection and placement program (hereinafter referred to as the program).

[Order R-69-1, § 284-19-010, filed 1/28/69.]

WAC 284-19-020 Purposes of program. The purposes of the program are:

(1) To assure stability in the property insurance market of this state.

(2) To encourage maximum use, in obtaining essential property insurance, of the available, normal insurance market provided by authorized insurers.

(3) To make essential property insurance available where it cannot be obtained through the normal insurance market, subject to the conditions hereinafter stated.

(4) To encourage the improvement of the condition of properties located in the urban areas of the state of Washington and to further orderly community development generally.

(5) To establish a FAIR plan (fair access to insurance requirements), an industry placement facility and a joint reinsurance association for the equitable distribution and placement of risks among insurers in the manner and subject to the conditions hereinafter stated.

[Order R-69-1, § 284-19-020, filed 1/28/69.]

WAC 284-19-030 Effective date. (1) The program shall become effective October 28, 1968.

(2) The program is intended to conform with the applicable provisions of the Urban Property Protection and Reinsurance Act of 1968, 82 Stat. 555, Public Law 90-448, as amended, and administrative rules and regulations, and other directives adopted pursuant thereto by the Secretary, U.S. Department of Housing and Urban Development.

[Order R-73-2, § 284-19-030, filed 3/30/73; Order R-69-1, § 284-19-030, filed 1/28/69.]

WAC 284-19-040 Participation. Participation in this program shall be mandatory for all insurers and fraternal benefit societies authorized to engage in the property insurance business in this state, who have "premiums written," as defined in this chapter.

[Order R-69-1, § 284-19-040, filed 1/28/69.]

WAC 284-19-050 Definitions. (1) "Insurer" means any insurance company or other organization licensed to write and engage in writing property insurance business, including the property insurance components of multiperil policies, on a direct basis, in this state.

(2) "Essential property insurance" means the coverage against direct loss to real and tangible personal property at a fixed location that is provided in the standard fire policy and extended coverage endorsement, and shall include also the perils of vandalism and malicious mischief and such additional lines of property insurance as may be designated by the secretary, or the commissioner. Essential property insurance specifically includes insurance against direct loss to property which is being constructed or rehabilitated (builder's risk coverage). It does not include automobile insurance; nor, unless designated by the secretary, insurance on farm or manufacturing risks.

(3) "Industry placement facility" (hereinafter referred to as the facility) means the organization formed by insurers to assist applicants in urban areas in securing essential property insurance and to administer the FAIR plan and the joint reinsurance association.

(4) "Inspection bureau" means the Washington surveying and rating bureau.

(5) "Urban area" includes the following municipalities and counties and such additional counties, municipalities, and definitive political subdivisions therein as may be added from time to time by the commissioner or the secretary:

Pasco	- All
King County	- All
Tacoma	- All

(6) "Premiums written" means gross direct premiums (excluding that portion of premiums on risks ceded to the joint reinsurance association) charged during the second preceding calendar year with respect to property in this state on all policies of property insurance and property insurance components of all multiperil policies, as defined and computed by the facility, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

(7) A "service insurer" shall be any company designated by the facility and approved by the commissioner to issue policies under this program.

(8) "Commissioner" means the commissioner of insurance of the state of Washington.

(9) "Secretary" means the Secretary, U.S. Department of Housing and Urban Development.

(10) "The act" means the Urban Property Protection and Reinsurance Act of 1968, 82 Stat. 555, Public Law 90-448, as amended.

[Order R-73-2, § 284-19-050, filed 3/30/73; Order R-70-1, § 284-19-050, filed 7/31/70; Order R-69-1, § 284-19-050, filed 1/28/69.]

WAC 284-19-060 FAIR plan—Inspections and reports. (1) Any person having an insurable interest in real or tangible personal property at a fixed location in an urban area shall be entitled, upon application therefor to the facility, to an inspection of the property by the inspection bureau at no cost to the applicant. The inspection may be requested by the property owner or his representative, the insurer or the insurance producer and need not be in writing. Requests for inspections shall be transcribed on a form approved by the facility. A deposit premium shall not be required as a precondition to inspection.

(2) The owner of the building need not be present for a tenant to obtain an inspection, but the inspection bureau must be provided full access to the property for which insurance is sought.

(3) An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photograph of the property may be taken during the inspection.

(4) During the inspection, the inspector shall point out features of structure and occupancy to the applicant or his representative, if present, and shall indicate those features which may result in condition charges if the risk is accepted. The inspector shall have no authority to advise whether any insurer will provide the coverage.

(5) After the inspection a copy of the completed inspection report, and any photograph, indicating the

pertinent features of building, construction, maintenance, occupancy and surrounding property shall be sent within five business days to the facility for distribution to a service insurer. The person requesting the inspection report may designate the service insurer to which the inspection report is to be referred.

(6) Included with the report shall be a rate make-up statement, including any condition charges or surcharges imposed by inspection or under the program, or under any substandard rating plan approved by the commissioner. A copy of the inspection report shall be made available to the applicant or his agent upon request.

[Order R-69-1, § 284-19-060, filed 1/28/69.]

WAC 284-19-070 FAIR plan business—Distribution and placement. (1) The facility may not require, as a precondition to the placement of business under the FAIR plan, that the applicant make a showing that he is unable to obtain insurance in the normal market, but the facility may require an agent or broker to furnish the facility with copies of documents or information showing what effort was made by such agent or broker to obtain insurance in the normal market, and the facility shall forward to the commissioner the names of such agents or brokers who fail to cooperate or who appear to fail to make reasonable efforts on behalf of applicants for insurance to obtain insurance in the normal market.

(2) Thereafter, the facility, upon receipt of an application for coverage and the corresponding inspection report from the inspection bureau, shall assign such application to the service insurer designated by the applicant or by his agent; or if no service insurer is so designated, it shall assign the application to a service insurer, keeping the assignments evenly distributed, based on the volume of property insurance writings in this state of the various service insurers.

(3) Assessments upon each insurer participating in this program shall be levied by the facility on the same percentage allocation basis as such insurer's premiums written bears to the total of all premiums written by all insurers participating in the program.

(a) The maximum limit of liability which may be placed through this program on any one property at one location is \$1,500,000. The facility shall undertake the responsibility of seeking to place that portion of a risk which exceeds \$1,500,000.

(b) The term "at one location" as used herein refers to real and personal property consisting of and contained in a single building, or consisting of and contained in contiguous buildings under one ownership.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.18.480, and 48.30.020. 79-08-019 (Order R 79-3), § 284-19-070, filed 7/11/79; Order R-69-1, § 284-19-070, filed 1/28/69.]

WAC 284-19-080 Procedure after inspection and submission. (1) Any service insurer to which a risk is referred by the facility shall, within three business days after receipt of the inspection report and application, complete an action report and return the same to the facility advising that:

(a) The risk is acceptable; or

(b) The risk will be acceptable if the improvements noted in the action report are made by the applicant and confirmed by reinspection; or

(c) The risk is not acceptable for the reasons stated in the action report.

(2) If the risk is accepted by the designated service insurer, and upon receipt of premium, the policy or binder shall be delivered within two business days. No producer shall have authority to bind the facility or any service insurer for any risk eligible for this program until acceptance of the risk and payment of premium.

(3) In the event a risk is declined because it fails to meet reasonable underwriting standards, the facility will so notify the applicant and the commissioner. Reasonable underwriting standards shall include, but not be limited to, the following:

(a) Physical condition of the property, such as its construction, heating, wiring, evidence of previous fires or general deterioration;

(b) Its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials;

(c) Other specific characteristics of ownership, condition, occupancy or maintenance which are violative of public policy and result in unreasonable exposures to loss. Neighborhood or area location or any environmental hazard beyond the control of the property owner shall not be deemed to be an acceptable criterion for declining a risk.

(4) In the event the risk is conditionally declined because the property does not meet reasonable underwriting standards, but can be improved to meet such standards, the facility shall promptly advise the applicant and the commissioner what improvements noted in the action report should be made to the property. Upon completion of the improvements by the applicant or property owner, the facility, when so notified, will have the property promptly reinspected and furnish the new inspection report to the previously designated service insurer.

(5) If the inspection of the property reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with the substandard rating plan approved by the commissioner. In this event, the facility shall advise the applicant of what improvements, if any, he may make to bring his property to insurable condition at unsurcharged rates.

(6) Any insurer, which is a member of a group of insurers under the same management or ownership, to which a referral is made under the program, may apply in behalf of the group for a combined distribution and placement quota under the program. Such group shall have the option of designating the insurer within the group to which the risk shall be referred.

[Order R-69-1, § 284-19-080, filed 1/28/69.]

WAC 284-19-090 Joint reinsurance association. (1) A joint reinsurance association (hereinafter referred to as the association): Is hereby created consisting of all insurers.

(2) The association shall be authorized to assume reinsurance on behalf of insurers and cede reinsurance on behalf of insurers on eligible risks written by insurers through the FAIR plan. The reinsurance assumed by the

association shall be for 100% of each risk written under this program under \$1,500,000.

(3) Each insurer shall participate in the total writings, expenses, profits and losses of the association in proportion to its premiums written.

(4) In the event any reinsuring member fails, by reason of insolvency, to pay its proportion of any expense or of any loss as an assuming reinsurer incurred by the facility under the program, such unpaid loss or expense shall be paid by the remaining members, each contributing in the manner provided for the distribution of expenses and losses under the program, deleting therefrom the proportion of the defaulting member. The facility shall be subrogated to the rights of the remaining members in any liquidation proceeding and shall have full authority on their behalf to exercise such rights in any action or proceeding.

[Order R-69-1, § 284-19-090, filed 1/28/69.]

WAC 284-19-100 Standard policy coverage—

Coding. All policies issued shall be for essential property insurance on standard policy forms, shall be separately coded, and shall be issued for a term of one year, at rates promulgated by the inspection bureau under filings approved by the commissioner. Individual company deviation filings shall not apply to risks written under this program.

[Order R-69-1, § 284-19-100, filed 1/28/69.]

WAC 284-19-110 Cancellation under this program.

(1) No insurer shall cancel a policy or binder issued under this program except for:

(a) Cause which would have been grounds for nonacceptance of the risk under the program had such cause been known to the insurer at the time of acceptance; or

(b) For nonpayment of premium; or

(c) With the approval of the governing committee.

(2) Notice of cancellation, together with a statement of the reason therefor, shall be sent to the insured with a copy sent to the facility.

(3) Any cancellation notice to the insured shall be accompanied by a statement that the insured has a right of appeal as hereinafter provided.

[Order R-69-1, § 284-19-110, filed 1/28/69.]

WAC 284-19-120 Right of appeal.

(1) Any applicant or insurer shall have a right of appeal to the committee, including the right to appear in person before the committee, if requested by the party seeking appeal.

(2) A decision of the committee may be appealed to the commissioner.

(3) Each denial of insurance under this program shall be accompanied by a statement setting forth the provisions of this section (WAC 284-19-120).

(4) Notification of appeal may be made to the committee through the manager of the facility or any member of the committee.

(5) All appeals to the committee or to the commissioner shall be in writing and must indicate in what respect the applicant feels aggrieved.

(6) Decisions of the committee on appeals to it shall be reduced to writing and shall be rendered within at least 15

business days after notification of appeal is received, unless delayed by mutual consent. The majority of committee members (3) must concur in all decisions adverse to the party seeking appeal.

(7) Appeals to the commissioner under this program shall, in all other respects not set forth herein, be handled in accordance with chapters 48.04 and 34.04 RCW (Administrative Procedure Act).

[Order R-69-1, § 284-19-120, filed 1/28/69.]

WAC 284-19-130 Commission. Commission under this program shall be 10 percent on the policy premium and shall be paid to the licensed producer designated by the applicant.

[Order R-69-1, § 284-19-130, filed 1/28/69.]

WAC 284-19-140 Administration. (1) This program shall be administered by a governing committee (hereinafter referred to as the committee) of the facility, subject to the supervision of the commissioner, and operated by a manager appointed by the committee.

(2) On and after September 1, 1979, the committee shall consist of nine members, including five insurers, one of which shall be elected from each of the following:

American Insurance Association, Alliance of American Insurers, National Association of Independent Insurers, all other stock insurers, and all other nonstock insurers. A sixth member shall be the insurer designated as the service insurer under the program (or, if there be more than one service insurer, the sixth member shall be such service insurer as the commissioner designates as the member). The other three members shall be individuals who are appointed by the commissioner to so serve, none of whom shall be interested, directly or indirectly in any insurer except as a policyholder. The individual members shall serve for a period of one year or until their successors are appointed. Not more than one insurer in a group under the same management or ownership shall serve on the committee at the same time. One of the six insurers on the governing committee shall be a domestic insurer.

[(3) The governing committee is hereby empowered to issue operating procedures and other directives to carry out the purposes of this plan, the act, and directives of the secretary and the commissioner pursuant thereto.]

[(4) Each person serving on the committee or any subcommittee thereof, each member of the facility, and each officer and employee of the facility shall be indemnified by the facility against all costs and expenses actually and necessarily incurred by him or it in connection with the defense of any action, suit, or proceeding in which he or it is made a party by reason of his or its being or having been a member of the committee, or a member or officer or employee of the facility except in relation to matters as to which he or it has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in the performance of his or its duties as a member of such committee, or a member or officer or employee of the facility. This indemnification shall not apply to any loss, cost, or expense on insurance policy claims under the program. Indemnification hereunder shall not be exclusive

of other rights to which such member or officer may be entitled as a matter of law.]

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.18.480, and 48.30.020. 79-08-019 (Order R 79-3), § 284-19-140, filed 7/11/79; Order R-69-1, § 284-19-140, filed 1/28/69.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 284-19-150 Annual and special meetings. (1)

There shall be an annual meeting of the insurers on a date fixed by the committee. The three aforementioned associations shall designate or elect their representatives to the committee. The two nonassociation groups of companies shall elect their respective representatives by a majority vote counted on a weighted basis in accordance with each insurer's premiums written and the aggregate premiums written for all insurers in the respective groups of companies. Representatives on the committee shall serve for a period of one year or until successors are elected or designated.

(2) A special meeting may be called at such time and place designated by the committee or upon the written request to the committee of any ten insurers, not more than one of which may be a group under the same management or ownership.

(3) Twenty days' notice of such annual or special meeting shall be given in writing by the committee to the insurers. A majority of the insurers shall constitute a quorum. Voting by proxy shall be permitted. Notice of any meeting shall be accompanied by an agenda for such meeting.

(4) Any matter, including amendment of this program, may be proposed and voted upon by mail, provided such procedure is unanimously authorized by the members of the committee present and voting at any meeting of the committee. If so approved by the committee, notice of any proposal shall be mailed to the insurers not less than twenty days prior to the final date fixed by the committee for voting thereon.

(5) At any regular or special meeting at which the vote of the insurers is or may be required on any proposal, including amendment to this program, or any vote of the insurers which may be taken by mail on any proposal, such votes shall be cast and counted on a weighted basis in accordance with each insurer's premiums written. A proposal shall become effective when approved by at least two-thirds of the votes cast on such weighted basis, except amendments to this program which will require administrative action by the commissioner.

[Order R-69-1, § 284-19-150, filed 1/28/69.]

WAC 284-19-160 Duties of the committee. (1)

The committee shall meet as often as may be required to perform the general duties of the administration of the program or on the call of the commissioner. Three insurers of the committee shall constitute a quorum.

(2) The committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds and

perform all other duties provided herein or necessary or incidental to the proper administration of the program. The adoption of or substantive changes in pension plans or employee benefit programs shall be subject to approval of the insurers. Assessments upon each insurer shall be levied on the basis of its premiums written.

(3) Annually the manager shall prepare an operating budget which shall be subject to approval of the committee. Such budget shall be furnished to the insurers after approval. Any contemplated expenditure in excess of or not included in the annual budget shall require prior approval by the committee.

(4) The committee shall furnish to all insurers and to the commissioner a written report of operations annually in such form and detail as the committee may determine.

[Order R-69-1, § 284-19-160, filed 1/28/69.]

WAC 284-19-165 Cooperation of producers. All licensed insurance agents and brokers shall provide full cooperation in carrying out the aims and the operation of the FAIR plan.

[Order R-69-1, § 284-19-165, filed 1/28/69.]

WAC 284-19-170 Public education and notices required. (1)

All insurers shall undertake a continuing public education program in cooperation with producers and others, to assure that the essential property insurance inspection and placement program receives adequate public attention.

(2) All insurers shall give any policyholder eligible for coverage under this program 30 days' notice of cancellation or refusal to renew (except in the case of nonpayment of premium or evidence of incendiarism), and shall explain the procedure for making application under this program in or accompanying such notice.

[Order R 77-1, § 284-19-170, filed 3/24/77; Order R-69-1, § 284-19-170, filed 1/28/69.]

WAC 284-19-180 Statistics, records and reports.

(1) **Statistics.** The facility shall maintain separate statistics on business written in accordance with this plan, and shall make the following quarterly report to the commissioner and to the secretary, and such additional reports as may be required by the commissioner.

(a) Number of requests for inspections,

(b) Number of risks inspected,

(c) The number of risks accepted, total and average premiums charged, high and low premiums,

(d) The number of risks declined, and

(e) The number of reinspections made on conditionally declined risks.

(2) **Records.** In addition to statistics, the facility shall maintain complete and separate records of all business transactions, including copies of all policies and endorsements issued in accordance with this plan.

(3) **Reports to members.** Regular reports of the facility's operations shall be submitted to all members by the committee, such reports to include, but not necessarily to be limited to, premiums written and earned, losses, including

loss adjustment expense, paid and incurred, all other expenses incurred and outstanding liabilities.

[Order R-69-1, § 284-19-180, filed 1/28/69.]

Chapter 284-20 WAC INSURANCE POLICIES

WAC

284-20-006	Washington Insurance Examining Bureau, Inc.— Audits to test adherence to rate filings.
284-20-010	Standard fire policies.
284-20-020	Time of inception and expiration.
284-20-030	Purpose.
284-20-040	Classification of risks and coverages.
284-20-050	Excluded coverages.
284-20-070	Catastrophe coverage.
284-20-100	Modification of form filing requirements.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-20-005	Washington Insurance Examining Bureau, Inc.—Rates and adhering to filings. [Statutory Authority: RCW 48.02.060. 80-04-018 (Order R 80-2), § 284-20-005, filed 3/13/80; Order R-68-4, § 284-20-005, filed 7/3/68, effective 9/1/68; Order 179, filed 3/10/64; Original Order 179, filed 1/8/63.] Repealed by 82-02-024 (Order R 81-9), filed 12/30/81. Statutory Authority: RCW 48.02.060.
284-20-031	Resolution and plan of National Association of Insurance Commissioners. [Adopted 7/31/53, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-060	Replacement or depreciation insurance—Policy and general rules effective December 20, 1947. [Order 12/17/47, effective 12/20/47, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-061	Replacement or depreciation insurance—General rules promulgated June 4, 1951. [Rules dated 6/1/51; made and filed in the commissioner's office 6/4/51, filed with code reviser 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-062	Replacement or depreciation insurance—Construction to allow coverage to be written in a separate policy. [Rule construing WAC 284-20-210; made 2/13/52, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-063	Replacement or depreciation insurance—General rules promulgated May 15, 1952. [General rules of 5/15/52, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.
284-20-064	Replacement or depreciation insurance—May be written as a surplus line subject. [Order of 12/26/47, filed 3/22/60.] Repealed by Order R 77-3, filed 5/20/77.

WAC 284-20-006 Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings. (1) In performing the duty of ascertaining that lawful premiums are being charged, the commissioner finds that it is not reasonable or necessary, with regard to any kind of insurance, to mandate that data relating to all policies issued be submitted for examination. He does find, however, that as to all kinds of insurance falling within the scope of chapter 48.19 RCW occasions may arise where, in order to ascertain that lawful rates are being charged, documents with respect to certain policies should be submitted for examination, and that such required submission should, in some instances, be on a random audit basis, and in some instances, by designation of certain specific policies.

(2) Based on the foregoing and pursuant to RCW 48.19.410, with respect to policies having an effective date on and after February 1, 1982, every insurer authorized to

write property or casualty insurance in the state of Washington:

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

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

(c) Shall make available to the Washington Insurance Examining Bureau, Inc. such policies and the related daily reports, binders, renewal certificates, endorsements, and other evidences of insurance or the cancellation thereof, as may be required by the commissioner for purposes of random audits designed to test the companies' adherence to rate filings.

[Statutory Authority: RCW 48.02.060. 82-02-024 (Order R 81-9), § 284-20-006, filed 12/30/81.]

WAC 284-20-010 Standard fire policies. (1) This regulation is promulgated pursuant to RCW 48.18.120(1) to define and effect reasonable uniformity in all basic contracts of fire insurance.

(2) All policies which include coverage against loss or damage by fire are hereby defined to be basic contracts of fire insurance unless they come within the scope of insurance code provisions, or regulations adopted by the commissioner, providing that they may be regarded as marine, inland marine, vehicle, or casualty policies.

(3) Except for the provisions of the next succeeding three paragraphs, no company shall issue any basic contract of fire insurance covering property or interest therein in this state other than on the form known as the 1943 New York Standard Fire Insurance Policy, herein referred to as the "standard fire policy": *Provided, however,* That such form shall be modified to conform to RCW 48.18.290 with respect to the number of days' notice of cancellation required. In addition, such form shall be modified as necessary to conform to WAC 284-20-020 with respect to inception and expiration times. Such modifications may be by endorsement.

(a) Insurers issuing a standard fire policy pursuant to this regulation are hereby authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy: *Provided, however,* That nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination provided such assumption clause has been filed with and approved by the commissioner in accordance with RCW 48.18.100.

(b) The pages of the standard fire policy issued pursuant to this regulation may be renumbered and the format

rearranged for convenience in the preparation of individual contracts, and to provide space for the listing of rates and premiums for coverages insured thereunder or under endorsement attached to or printed thereon, and such other data as may be conveniently included for duplication on daily reports for office records.

(c) As an alternative form, a form written in clear, understandable language, which provides terms, conditions and coverages not less favorable to the insured than the "standard fire policy," may be used. Such alternative form may be incorporated in or integrated within a form providing other or additional coverages, as, for example, a homeowners policy or a special multi-peril policy. The intent of this subsection is to permit understandable plain language policies and package policies without diminishing any rights an insured would have under the 1943 New York Standard Fire Insurance Policy.

(d) By use of such alternative form, an insurer certifies that it is not less favorable to the insured than the "standard fire policy." If, in the adjustment of claims, any provision of the "standard fire policy" applicable to such claims is found to be more favorable to the insured than the alternative form used, then provisions of the "standard fire policy" shall govern.

[Order R 77-2, § 284-20-010, filed 4/28/77; Rule 128, filed 3/14/61.]

WAC 284-20-020 Time of inception and expiration.

Until January 1, 1978, any contract of insurance containing a basic contract of fire insurance shall provide that its time of inception and expiration are either noon or 12:01 a.m. standard time. Every such contract issued on or after January 1, 1978, shall provide only 12:01 a.m. standard time as the time of inception and expiration. Such contract, by endorsement or otherwise, shall also contain language in substance as follows: "To the extent that coverage contained in this policy replaces coverage in another policy terminating at a different hour on the effective date of this policy, this policy shall be effective at the same hour as the termination hour of the other policy."

[Order R 77-2, § 284-20-020, filed 4/28/77.]

WAC 284-20-030 Purpose. (1) The purpose of this regulation, WAC 284-20-030 through 284-20-050, is to describe the kinds of risks and coverages which may be classified under the insurance code as marine, inland marine or transportation insurance, but does not include all of the kinds of risks and coverages which may be written, classified or identified under marine, inland marine or transportation insuring powers, nor shall it be construed to mean that the kinds of risks and coverages are solely marine, inland marine or transportation insurance in all instances.

(2) This regulation shall not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and license whether used separately, in combination or otherwise.

[Order R 77-3, § 284-20-030, filed 5/20/77; Rule made 7/31/53, filed 3/22/60.]

WAC 284-20-040 Classification of risks and coverages. Marine and/or transportation policies may cover under the following conditions:

(1) Imports.

(a) Imports may be covered wherever the property may be and without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(b) An import, as a proper subject of marine or transportation insurance, shall be deemed to maintain its character as such, so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:

(i) Sold and delivered by the importer, factor or consignee; or

(ii) Removed from place of storage and placed on sale as part of importer's stock in trade at a point of sale-distribution; or

(iii) Delivered for manufacture, processing or change in form to premises of the importer or of another used for any such purposes.

(2) Exports.

(a) Exports may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(b) An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this ruling respecting domestic shipments shall apply, provided, however, that this provision shall not apply to long established methods of insuring certain commodities, e.g., cotton.

(3) Domestic shipments.

(a) Domestic shipments on consignment, for sale, distribution, exhibit, trial, approval or auction, while in transit, while in the custody of others, and while being returned, provided that in no event shall the policy afford coverage on premises owned, leased or operated by the consignor.

(b) Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, provided that such shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by insured or purchaser.

(4) **Bridges, tunnels and other** instrumentalities of transportation and communication (excluding buildings, their improvements and betterments, furniture and furnishings, fixed contents and supplies held in storage). The foregoing includes:

(a) Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto.

(b) Piers, wharves, docks, slips, dry docks and marine railways.

(c) Pipelines, including on-line propulsion, regulating and other equipment appurtenant to such pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants.

(d) Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges.

(e) Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus.

(f) Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.

(5) **Personal property floater risks** covering individuals and/or generally:

(a) Personal effects floater policies.

(b) The personal property floater.

(c) Government service floaters.

(d) Personal fur floaters.

(e) Personal jewelry floaters.

(f) Wedding present floaters for not exceeding ninety days after the day of the wedding.

(g) Silverware floaters.

(h) Fine arts floaters covering paintings, etchings, pictures, tapestries, art glass windows, and other bonafide works of art of rarity, historical value or artistic merit.

(i) Stamp and coin floaters.

(j) Musical instrument floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(k) Mobile articles, machinery and equipment floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use) covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(l) Installment sales and leased property policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest.

(m) Live animal floaters.

(6) **Commercial property floater risks** covering property pertaining to a business, profession or occupation, as follows:

(a) Radium floaters.

(b) Physicians' and surgeons' instrument floaters. Such policies may include coverage of such furniture, fixtures and tenant insured's interest in such improvements and betterments of buildings as are located in that portion of the premises occupied by the insured in the practice of his profession.

(c) Pattern and die floaters.

(d) Theatrical floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes.

(e) Film floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records.

(f) Salesmen's samples floaters.

(g) Exhibition policies on property while on exhibition and in transit to or from such exhibitions.

(h) Live animal floaters.

(i) Builders risks and/or installation risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating or repairing. Such policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.

(i) Such coverage shall be limited to builders risks or installation risks where perils in addition to fire and extended coverage are to be insured.

(ii) If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverages shall terminate when the interest of the seller or contractor ceases.

(j) Mobile articles, machinery and equipment floaters (excluding motor vehicles designed for highway use and auto homes, trailers and semitrailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use), covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into custody or control of parties who intend to use such property for the purpose for which it was manufactured or created. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(k) Property in transit to or from and in the custody of bailees (not owned, controlled or operated by the bailor.) Such policies shall not cover bailee's property at his premises.

(l) Installment sales and leased property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. Such policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This section is not intended to include machinery and equipment under certain "lease-back" contracts.

(m) Garment contractors floaters.

(n) Furriers or fur storer's customer's policies (i.e., policies under which certificates or receipts are issued by furriers or fur storers) covering specified articles the property of customers.

(o) Accounts receivable policies, valuable papers and records policies.

(p) Floor plan policies, covering property for sale while in possession of dealers under a floor plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

(i) Such merchandise is specifically identifiable as encumbered to the bank or lending institution.

(ii) The dealer's right to sell or otherwise dispose of such merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.

(iii) Such policies cover in transit and do not extend beyond the termination of the dealer's interest.

Such policies shall not cover automobiles or motor vehicles, nor merchandise for which the dealer's collateral is

the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

(q) Sign and street clock policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.

(r) Fine arts policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bonafide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.

(s) Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically, by the owner, under inland marine policies including:

(i) Musical instrument dealers policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(ii) Camera dealers policies, covering property consisting principally of cameras and their accessories.

(iii) Furrier's dealers policies, covering property consisting principally of furs and fur garments.

(iv) Equipment dealers policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefor; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools and similar equipment and accessories therefor; but excluding motor vehicles designed for highway use.

(v) Stamp and coin dealers covering property of philatelic and numismatic nature.

(vi) Jewelers' block policies.

(vii) Fine arts dealers policies.

Such policies may include coverage of money in locked safes or vaults on the insured's premises. Such policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insured's interest in improvements of buildings.

(t) Wool growers floaters.

(u) Domestic bulk liquids policies, covering tanks and domestic bulk liquids stored therein.

(v) Difference in conditions coverage excluding fire and extended coverage perils.

(w) Electronic data processing policies.

[Order R 77-3, § 284-20-040, filed 5/20/77; Rule made 7/31/53, filed 3/22/60.]

WAC 284-20-050 Excluded coverages. Unless otherwise permitted, nothing in WAC 284-20-030 or 284-20-040 shall be construed to permit marine or transportation policies to cover:

(1) Storage of insured's merchandise, except as hereinbefore provided.

(2) Merchandise in course of manufacture, the property of and on the premises of the manufacturer.

(3) Furniture and fixtures and improvements and betterments to buildings.

(4) Monies and/or securities in safes, vaults, safety deposit vaults, bank or insured's premises, except while in course of transportation.

[Order R 77-3, § 284-20-050, filed 5/20/77; Rule made 1/31/56, filed 3/22/60.]

WAC 284-20-070 Catastrophe coverage. See WAC 284-24-050.

WAC 284-20-100 Modification of form filing requirements. Pursuant to RCW 48.18.100(6), the commissioner rules and hereby orders that all insurance documents and forms pertaining to surplus line coverages placed in this state pursuant to chapter 48.15 RCW are exempt from the requirements of RCW 48.18.100, hereby confirming the long-standing practice in this state.

[Statutory Authority: RCW 48.02.060 (3)(e). 86-24-043 (Order R 86-7), § 284-20-100, filed 11/26/86.]

Chapter 284-21 WAC STANDARD FORMS

WAC

284-21-010

Loss payable and mortgagee endorsements.

284-21-990

Appendix—Form—Loss payable endorsement.

WAC 284-21-010 Loss payable and mortgagee endorsements. After March 1, 1968, no new policy of automobile physical damage insurance or property insurance covering property located in the state of Washington shall be endorsed with a long form loss payable or mortgagee clause, other than:

(1) For automobile physical damage insurance, the form attached to this regulation, which is here designated Form REG-335.

(2) For property insurance, either:

(a) What is now called Standard Forms Bureau Form 372 (Nov. 1950) or the NS version of the same form, which may be adapted for use with insurance on personal property by typing over or deleting from the form the phrase "on buildings only;" or

(b) What is now called Form 438 BFU (May 1, 1942), as approved by the Board of Fire Underwriters of the Pacific and California Bankers Association Insurance Committee, or the NS version of the same form, which may be adopted for use with insurance on personal property by typing over or deleting from the form the phrase "on buildings only;" or

(c) Form REG-335 (see appendix [codified as WAC 284-21-990] at end of this chapter).

Specimens of the above forms may be obtained without cost by calling or writing to the Office of Insurance Commissioner, Insurance Building, Olympia, Washington.

[Order R-68-5, § 284-21-010, filed 7/9/68.]

WAC 284-21-990 Appendix—Form—Loss payable endorsement.

LOSS PAYABLE ENDORSEMENT

This form is identical to that promulgated in Washington State Insurance Commissioner's Regulation No. 335, pursuant to section 1, chapter 12, Laws of 1967, ex. sess., State of Washington.

1. Loss or damage, if any, under this policy shall be payable first to the loss payee or mortgagee (hereinafter called secured party), and, second, to the insured, as their interests may appear; *Provided*, That, upon demand for separate settlement by the secured party, the amount of said loss shall be paid directly to the secured party to the extent of its interest.

2. This insurance as to the interest of the secured party shall not be invalidated by any act or neglect of the insured named in said policy or his agents, employees or representatives, nor by any change in the title or ownership of the insured property: *Provided, however*, That, the conversion, embezzlement or secretion by the named insured or his agents, employees or representatives is not covered under said policy unless specifically insured against and premiums paid therefor.

3. In applying the pro rata provisions of the policy, the amount payable to the secured party shall be reduced only to the extent of pro rata payments receivable by the secured party under other policies.

4. The company reserves the right to cancel the policy at any time as provided by its terms, but in such case the company shall mail to the secured party a notice stating when such cancellation shall become effective as to the interest of said secured party. The amount and form of such notice shall be not less than that required to be given the named insured, by law or by the policy provisions, whichever is more favorable to the secured party.

5. If the insured fails to render proof of loss within the time granted in the policy conditions, such secured party shall do so within sixty days after having knowledge of a loss, in form and manner as provided by the policy, and, further, shall be subject to the provisions of the policy relating to appraisal and the time of payment and bringing suit.

6. Whenever the company shall pay the secured party any sum for loss or damage under policy and shall claim that, as to the insured, no liability exists, the company shall, to the extent of such payment, be thereupon legally subrogated to all the rights of the party to whom such payment shall be made, under all collateral held to secure the debt, or may, at its option, pay to the secured party the whole principal due or to grow due on the mortgage or other security agreement, with interest, and shall thereupon receive a full assignment and transfer of the mortgage or other security agreement and of all collateral held to secure it; but no subrogation shall impair the right of the secured party to recover the full amount due it.

7. All terms and conditions of the policy remain unchanged except as herein specifically provided.

8. All notices sent to the secured party shall be sent to its last reported address, which must be stated in the policy or in this endorsement below.

9. The following item shall be completed if this endorsement is not referred to by number in the policy to which this endorsement is attached:

The foregoing is attached to and forms a part of Policy No. of Insurance Company, issued to Endorsement effective date, 19. . .

10. If the secured party and its address is not designated in the policy to which this endorsement is attached, the following line(s) shall be completed:

Secured Party Secured Party
Address: Address:
By
Agent

[Order R-68-5 (codified as WAC 284-21-990), filed 7/9/68; Order 335, filed 1/3/68.]

Chapter 284-22 WAC
USL&H ASSIGNED RISK PLAN

WAC
284-22-010 Title.
284-22-020 Purpose.
284-22-030 Effective date.
284-22-040 Territory.
284-22-050 Definitions.
284-22-060 Participation.
284-22-070 Administration.
284-22-080 Approval by commissioner.
284-22-090 Right of appeal.

WAC 284-22-010 Title. These rules and regulations, adopted under the authority of chapter 177, Laws of 1993, shall be entitled the Washington United States Longshore and Harbor Workers' Compensation Act assigned risk plan (hereinafter referred to as "the assigned risk plan").

[Statutory Authority: RCW 48.02.060. 93-20-019 (Order R 93-17), § 284-22-010, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209. 92-19-095 (Order R 92-12), § 284-22-010, filed 9/16/92, effective 10/17/92.]

WAC 284-22-020 Purpose. The purposes of the assigned risk plan are:

(1) To promote a strong and healthy maritime industry, within Washington state, by ensuring the continued availability of workers' compensation coverage required by the United States Longshore and Harbor Workers' Act and maritime employers' liability coverage incidental to such

workers' compensation coverage for employers who are unable to purchase it through the normal insurance market.

(2) To provide a mechanism through which the underwriting results of the assigned risk plan are shared by authorized insurers writing primary or excess United States Longshore and Harbor Workers' insurance within Washington state and the Washington state industrial insurance fund.

[Statutory Authority: RCW 48.02.060, 93-20-019 (Order R 93-17), § 284-22-020, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-020, filed 9/16/92, effective 10/17/92.]

WAC 284-22-030 Effective date. (1) The assigned risk plan shall become effective at 12:01 a.m. July 1, 1992.

(2) The assigned risk plan shall cease accepting new applicants at 12:01 a.m. July 1, 1995. However, it shall not terminate until all policies issued under the plan have expired and outstanding obligations incurred under such policies have been satisfied.

[Statutory Authority: RCW 48.02.060, 93-20-019 (Order R 93-17), § 284-22-030, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-030, filed 9/16/92, effective 10/17/92.]

WAC 284-22-040 Territory. The assigned risk plan shall provide coverage only for employers who are unable to purchase United States longshore and harbor workers' coverage and maritime employers' liability coverage incidental to such workers' compensation coverage for their operations within the state of Washington.

[Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-040, filed 9/16/92, effective 10/17/92.]

WAC 284-22-050 Definitions. (1) "Administrator" means any organization designated by the assigned risk plan and approved by the commissioner to provide administrative support for the plan. Such support shall be defined by the governing committee in its operating plan. It may include, but is not limited to, acceptance, processing, and distribution of incoming applications to the servicing carrier(s), collection of and accounting for premium income, determination of assigned risk plan reserves, investment of assigned risk plan assets, collection of statistical data, actuarial assistance for rate making, development of policy contracts, and auditing the activities of servicing carrier(s) to ensure that the assigned risk plan's rules are being applied properly.

(2) "Applicant" means an employer, seeking coverage from the assigned risk plan, who has, in good faith, sought United States longshore and harbor workers' coverage from at least two of the authorized insurers writing such coverage in Washington and has been declined such coverage by all insurers from which it has sought coverage. "Applicant" does not include employers seeking coverage through the plan solely because of the lack of availability of maritime employers' liability coverage.

(3) "Authorized insurer" means any insurance company licensed to write workers' compensation insurance on a direct basis in this state.

(4) "Commissioner" means the commissioner of insurance of the state of Washington.

(5) "Governing committee" means the committee responsible for administering the assigned risk plan. It shall consist of thirteen members, who shall be appointed by the commissioner. The director of the department of labor and industries shall be one member. The remaining members shall be selected to insure equal representation of each of the following interest groups; authorized insurers writing primary or excess workers' compensation insurance, insurance producers, organized labor, and maritime employers.

(6) "Maritime employers' liability" means that liability imposed by 46 U.S.C. 688 (the Jones Act) and general maritime law for bodily injury including death of a master or member of the crew of any vessel.

(7) "Servicing carrier" means any authorized insurer designated by the assigned risk plan and approved by the commissioner and the United States Department of Labor to issue workers' compensation policies. It shall issue policies on behalf of the assigned risk plan, provide safety engineering, handle claims incurred by those covered by the assigned risk plan, provide premium audits, perform underwriting functions, and perform other duties as defined by the governing committee in its operating procedures.

(8) "State industrial insurance fund" means that entity defined in RCW 51.08.175 which provides primary workers' compensation insurance on a direct basis in this state.

(9) "Underwriting results" means the assigned risk plan's revenues less incurred claims plus net operating expenses, net of reinsurance, during its period of operation.

(10) "United States longshore and harbor workers' compensation coverage" means that workers' compensation coverage required of employers by the United States Longshore and Harbor Workers' Compensation Act, 33 U.S.C. Secs. 901 through 950. It is hereinafter referred to as USL&H coverage.

(11) "Written premium" means gross direct premiums (excluding premiums on risks written ceded to the assigned risk plan), within the state of Washington, charged during the first preceding calendar year with respect to United States Longshore and Harbor Workers' insurance, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

[Statutory Authority: RCW 48.02.060, 93-20-019 (Order R 93-17), § 284-22-050, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-050, filed 9/16/92, effective 10/17/92.]

WAC 284-22-060 Participation. (1) Participation in the assigned risk plan is mandatory for all authorized insurers writing primary or excess United States Longshore and Harbor Workers' insurance in Washington state and the state industrial insurance fund. Underwriting results shall be shared by the participants in accordance with the following ratio: The state industrial insurance fund, fifty percent; authorized insurers writing such United States Longshore and Harbor Workers' coverage, fifty percent.

(2) The amount of participation of each authorized insurer shall be based on the proportional share of its United States Longshore and Harbor Workers' compensation premium written within Washington to all such premium written within the appropriate category during the first preceding calendar year. However, the governing committee, subject to the commissioner's approval, and subject to

the requirement that the amount assumed by all insurers within each category must be as stated in subsection (1) of this section, has the authority to allocate assessments in such a fashion that no authorized insurer shall be required to participate in the plan if the amount of an assessment shall be less than fifty dollars.

(3) Each authorized insurer writing United States Longshore and Harbor Workers' insurance shall by September 1 of each calendar year make a report to the governing committee identifying the amount of its written premium in the preceding year applying to United States Longshore and Harbor Workers' coverage and the amount applying to excess workers' compensation coverage.

[Statutory Authority: RCW 48.02.060, 93-20-019 (Order R 93-17), § 284-22-060, filed 9/24/93, effective 10/25/93. Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-060, filed 9/16/92, effective 10/17/92.]

WAC 284-22-070 Administration. (1) The governing committee shall be responsible for the administration of the assigned risk plan.

(2) The committee shall meet at least once each calendar quarter. Seven members shall constitute a quorum, provided that the department of labor and industries and each of the defined interest groups must be represented.

(3) Members of the governing committee shall serve without compensation. However, each person serving on the governing committee or any subcommittee thereof shall be indemnified by the assigned risk plan for all costs and expenses actually and necessarily incurred in connection with the defense of any action, suit, or proceeding in which such person is a named party by reason of being a member of the governing committee. This indemnification shall not apply in those instances in which the person has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in performance of his/her duties as a member of the committee.

(4) The committee shall:

(a) Select a presiding officer.

(b) Draft and submit to the commissioner for approval operating procedures for the assigned risk plan. Such procedures shall be drafted to carry out the purposes of chapter 209, Laws of 1992. These procedures shall include, but are not limited to, provisions:

(i) Defining the specific conditions under which employers become eligible for coverage.

(ii) Defining the role and functions of the administrator.

(iii) Defining the role and function of the servicing carrier(s). These roles shall include the requirement that the servicing(s) carrier file the assigned risk plan's policy forms and rates with the commissioner, on its behalf, prior to use.

(iv) Establishing specific procedures for the control of the assigned risk plan's funds. These procedures shall ensure that anyone handling funds do so responsibly.

(v) Defining standard policy forms similar to those used for USL&H and maritime employers' liability coverage in the voluntary market within Washington and requiring the use of such forms by the servicing carrier(s).

(vi) Defining how the rates to be used by the servicing carrier(s) shall be established. The procedures shall require that rates be developed in an actuarially sound manner.

They must also require that the servicing carrier(s) use these rates when issuing assigned risk policies.

(vii) Establishing how an applicant's eligibility for maritime employers' liability will be determined. The procedure must provide an eligibility test to be applied at the time of acceptance of the applicant for such coverage and not upon receipt of notice of a claim.

(viii) Defining the limits of maritime employers' liability coverage to be offered by the assigned risk plan. The assigned risk plan must offer such coverage with limits up to one hundred thousand dollars per occurrence. It may provide higher limits if the governing committee deems such limits are necessary to promote its purpose.

(ix) Defining a procedure under which appeals received from applicants, persons insured, or participating insurers aggrieved by any action or decision of the assigned risk plan will be received, investigated, and resolved.

(c) Select an administrator.

(d) Select the servicing carrier(s).

(e) Retain such accounting, actuarial, clerical, professional, or other services as the committee deems necessary to operate the assigned risk plan in a sound and competent manner.

(f) Maintain separate statistics on business written by the assigned risk plan. These statistics shall be in sufficient detail to permit the committee and the commissioner to determine the financial condition of the plan when necessary. In any event, the committee shall make quarterly reports to the commissioner providing the following information:

(i) The number of applications received by the administrator.

(ii) The number of policies issued.

(iii) The amount of premiums written during the previous quarter and year-to-date.

(iv) The amount of losses incurred and paid, and allocated loss adjustment expense incurred and paid during the previous quarter and year-to-date.

(g) Initiate and carry out, with the approval of the commissioner, such interim and regular assessments of those participating in the assigned risk plan as may be necessary and reasonable for its operation in a sound and competent manner.

(h) Take such other actions as the committee considers necessary and appropriate to properly administer the activities of the assigned risk plan.

[Statutory Authority: RCW 48.02.060 and 1992 c 209, 92-19-095 (Order R 92-12), § 284-22-070, filed 9/16/92, effective 10/17/92.]

WAC 284-22-080 Approval by commissioner. (1)

The commissioner shall approve the assigned risk plan's operating procedures if they provide for the fair, reasonable, and equitable administration of the assigned risk plan for all concerned.

(2) The commissioner shall approve rate and form filings made by the servicing carrier(s) on behalf of the plan using the same standards that would apply to an insurance program designed and filed with the commissioner by an authorized insurer.

(3) The commissioner shall approve the assigned risk plan's requests for interim and regular assessments upon receipt of evidence that such assessments are necessary to

insure its continued operation in a sound and competent manner.

[Statutory Authority: RCW 48.02.060 and 1992 c 209. 92-19-095 (Order R 92-12), § 284-22-080, filed 9/16/92, effective 10/17/92.]

WAC 284-22-090 Right of appeal. Any applicant, person insured under the plan, or participating insurer, aggrieved by a ruling or decision of the plan shall have a right to appeal such decision to the commissioner. Appeals to the commissioner under this program shall in all other respects not set forth herein, be handled in accordance with chapters 48.04 and 34.05 RCW.

[Statutory Authority: RCW 48.02.060 and 1992 c 209. 92-19-095 (Order R 92-12), § 284-22-090, filed 9/16/92, effective 10/17/92.]

Chapter 284-23 WAC

WASHINGTON LIFE INSURANCE REGULATIONS

WAC

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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.

ADVERTISING REGULATION

WAC 284-23-010 Title and purpose. (1) This regulation, WAC 284-23-010 through 284-23-130, shall be known and may be cited as the "Washington life insurance advertising regulation."

(2) The purpose of this regulation is to set forth minimum standards and guidelines to assure a full and truthful disclosure to the public of all material and relevant information in the advertising of life insurance policies and annuity contracts.

[Order R-75-3, § 284-23-010, filed 8/22/75, effective 11/1/75.]

WAC 284-23-020 Definitions. (1) For the purpose of this regulation:

(a) "Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for life insurance or annuity benefits.

(b) "Insurer" shall include any organization or person which issues life insurance or annuities in this State and is engaged in the advertisement of a policy.

(c) "Advertisement" shall be material designed to create public interest in life insurance or annuities or in an insurer, or to induce the public to purchase, increase, modify, reinstate, or retain a policy including:

(i) Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

(ii) Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters;

(iii) Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors and brokers which is designed to be used or is used to induce the public to purchase, increase, modify, reinstate or retain a policy;

(iv) Prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

(2) "Advertisement" for the purpose of this regulation shall not include:

(a) Communications or materials used within an insurer's own organization and not intended for dissemination to the public;

(b) Communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate or retain a policy;

(c) A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

[Order R-75-3, § 284-23-020, filed 8/22/75, effective 11/1/75.]

WAC 284-23-030 Applicability. (1) This regulation shall apply to any life insurance or annuity advertisement intended for dissemination in this state.

(2) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

[Order R-75-3, § 284-23-030, filed 8/22/75, effective 11/1/75.]

WAC 284-23-040 Form and content of advertisements. (1) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a policy shall be sufficiently complete and

clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive.

(2) Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(3) No advertisement shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," or other similar terms in connection with a policy in a context or under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser of such policy to believe that he will receive, or that it is possible that he will receive, something other than a policy or some benefit not available to other persons of the same class and equal expectation of life.

[Order R-75-3, § 284-23-040, filed 8/22/75, effective 11/1/75.]

WAC 284-23-050 Disclosure requirements. (1) The information required to be disclosed by these rules shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(2) No advertisement shall omit material information or use words, phrases, statements, references or illustrations if such omission or such use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, premium payable or state or federal tax consequences. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale, or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(3) In the event an advertisement uses "nonmedical," "no medical examination required," or similar terms where issue is not guaranteed, such terms shall be accompanied by a further disclosure of equal prominence and in juxtaposition thereto to the effect that issuance of the policy may depend upon the answers to the health questions.

(4) An advertisement shall not use as the name or title of a life insurance policy or an annuity any phrase which does not include the words "life insurance" or "annuity" unless accompanied by other language clearly indicating it is life insurance or an annuity.

(5) An advertisement shall prominently describe the type of policy advertised.

(6) An advertisement of an insurance policy marketed by direct response techniques shall not state or imply that because there is no agent or commission involved there will be a cost saving to prospective purchasers unless such is the fact. No such cost savings may be stated or implied without justification satisfactory to the insurance commissioner prior to use.

(7) An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or

increases with age or duration, such fact shall be prominently disclosed.

(8) An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

(9) With respect to dividends:

(a) An advertisement shall not utilize or describe dividends in a manner which is misleading or has the capacity or the tendency to mislead.

(b) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends are illustrated, they must be based on the insurer's current dividend scale and the illustration must contain a statement to the effect that they are not to be construed as guarantees or estimates of dividends to be paid in the future.

(c) An advertisement shall not state or imply that illustrated dividends under a participating policy and/or pure endowments will be or can be sufficient at any future time to assure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains what benefits or coverage would be provided at such time and under what conditions this would occur.

(10) An advertisement shall not state that a purchaser of a policy will share in or receive a stated percentage or portion of the earnings on the general account assets of the company.

(11) With respect to testimonials or endorsements by third parties:

(a) Testimonials used in advertisements must be genuine; represent the current opinion of the author; be applicable to the policy advertised, if any; and be accurately reproduced. In using a testimonial the insurer makes as its own all of the statements contained therein, and such statements are subject to all the provisions of this regulation.

(b) If the individual making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, such fact shall be disclosed in the advertisement.

(c) An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by a group of individuals, society, association or other organization unless such is the fact and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial is owned, controlled, or managed by the insurer, or receives any payment or other consideration from the insurer for making such endorsement or testimonial, such fact shall be disclosed in the advertisement.

(12) An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

(13) With respect to introductory, initial, or special offers and enrollment periods:

(a) An advertisement of an individual policy or combination of such policies shall not state or imply that such policy or combination of such policies is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that

the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not describe an enrollment period as "special" or "limited" or use similar words or phrases in describing it when the insurer uses successive enrollment periods as its usual method of marketing its policies.

(b) An advertisement shall not state or imply that only a specific number of policies will be sold or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy.

(c) An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which over-emphasizes the availability and the amount of the reduced initial premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, all references to the reduced initial premium shall be followed by an asterisk or other appropriate symbol which refers the reader to that specific portion of the advertisement which contains the full rate schedule for the policy being advertised.

(d) An enrollment period during which a particular insurance policy may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same policy and the opening of the new enrollment period. The advertisement shall specify the date by which the applicant must mail the application, which shall be not less than ten days and not more than forty days following the date on which such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals used by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This rule does not apply to the use of a termination or cutoff date beyond which an individual application for a guaranteed issue policy will not be accepted by an insurer in those instances where the application has been sent to the applicant in response to his request. It is also inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the insurance code for group, blanket or franchise insurance. In cases where an insurance product is marketed on a direct mail basis to prospective insureds by reason of some common relationship with a sponsoring organization, this rule shall be applied separately to each such sponsoring organization.

(14) An advertisement of a particular policy shall not state or imply that prospective insureds shall be or become members of a special class, group or quasi-group and as such enjoy special rates, dividends or underwriting privileges, unless such is the fact.

(15) An advertisement shall not make unfair or incomplete comparisons of policies, benefits, dividends or rates of other insurers. An advertisement shall not falsely or unfairly describe other insurers, their policies, services or methods of marketing.

[Order R-75-3, § 284-23-050, filed 8/22/75, effective 11/1/75.]

WAC 284-23-060 Identity of insurer. (1) The full name and home office of the insurer shall be clearly identified, and if any specific individual policy is advertised it shall be identified either by form number or other appropriate description. An advertisement shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device or reference without disclosing the name of the insurer, or in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the insurer or create the impression that a company other than the insurer would have any responsibility for the financial obligation under a policy.

(2) No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a governmental program or agency or otherwise appear to be of such a nature that they tend to mislead prospective insureds into believing that the solicitation is in some manner connected with such governmental program or agency.

[Order R-75-3, § 284-23-060, filed 8/22/75, effective 11/1/75.]

WAC 284-23-070 Solicitation beyond license limits and status of insurer. (1) An advertisement which reasonably is expected to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply solicitation beyond such limits.

(2) An advertisement may state that an insurer is licensed in the state where the advertisement appears, provided it does not exaggerate such fact or suggest or imply that competing insurers may not be so licensed.

(3) An advertisement shall not create the impression that the insurer, its financial condition or status, the payment of its claim, or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are recommended or endorsed by any governmental entity. However, where a governmental entity has recommended or endorsed a policy form or plan, such fact may be stated if the entity authorizes its recommendation or endorsement to be used in an advertisement.

[Order R-75-3, § 284-23-070, filed 8/22/75, effective 11/1/75.]

WAC 284-23-080 Statements about the insurer. An advertisement shall not contain statements, pictures or illustrations which are false or misleading, in fact or by implication, with respect to the assets, liabilities, insurance in force, corporate structure, financial condition, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly defines the scope and extent of the recommendation.

[Order R-75-3, § 284-23-080, filed 8/22/75, effective 11/1/75.]

WAC 284-23-090 Advertising file to be maintained. Each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its individual policies and specimen copies of typical printed, published or prepared

advertisements of its blanket, franchise and group policies, hereafter disseminated in this State, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance commissioner. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-75-3, § 284-23-090, filed 8/22/75, effective 11/1/75.]

WAC 284-23-100 Conflict with other rules. It is not intended that these rules conflict with or supersede any rules currently in force or subsequently adopted in this state governing specific aspects of the sale or replacement of life insurance including, but not limited to, rules dealing with life insurance cost comparison indices, deceptive practices in the sale of life insurance and replacement of life insurance policies. Consequently, no disclosure required under any such rules shall be deemed to be an advertisement within the meaning of this regulation.

[Order R-75-3, § 284-23-100, filed 8/22/75, effective 11/1/75.]

WAC 284-23-110 Violation defined as unfair practice. A violation of this regulation, WAC 284-23-010 through 284-23-130, is hereby defined to be an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010.

[Order R-75-3, § 284-23-110, filed 8/22/75, effective 11/1/75.]

WAC 284-23-120 Severability provision. If any section or portion of a section of this regulation, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the regulation, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Order R-75-3, § 284-23-120, filed 8/22/75, effective 11/1/75.]

WAC 284-23-130 Effective date. The effective date of this regulation, WAC 284-23-010 through 284-23-130, shall be November 1, 1975.

[Order R-75-3, § 284-23-130, filed 8/22/75, effective 11/1/75.]

SOLICITATION REGULATION

WAC 284-23-200 Purpose. (1) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

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

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-200, filed 6/25/79, effective 1/1/80.]

WAC 284-23-210 Scope. (1) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This regulation shall apply to any issuer of life insurance contracts including fraternal mutual life insurers.

(2) Unless otherwise specifically included, this regulation shall not apply to:

- (a) Annuities.
- (b) Credit life insurance.

(c) Group life insurance whose cost is borne in whole or in part by the individual insured's employer or by an association of which the individual insured is a member.

(d) Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

(e) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-210, filed 6/25/79, effective 1/1/80.]

WAC 284-23-220 Definitions. For the purposes of this regulation, the following definitions shall apply:

(1) "Buyer's guide." A buyer's guide is a document which contains, and is limited to, the language contained in WAC 284-23-270 or language approved by the commissioner.

(2) "Cash dividend." A cash dividend is the current illustrated dividend which can be applied toward payment of the gross premium.

(3) "Equivalent level annual dividend." The equivalent level annual dividend is calculated by applying the following steps:

(a) Accumulate the annual cash dividends at five percent interest compounded annually to the end of the tenth and twentieth policy years.

(b) Divide each accumulation of step (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in step (a) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(c) Divide the results of step (b) by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

(4) "Equivalent level death benefit." The equivalent level death benefit of a policy or term life insurance rider is an amount calculated as follows:

(a) Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and twenty years at five percent interest compounded annually to the end of the tenth and twentieth policy years respectively.

(b) Divide each accumulation of step (a) by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step (a) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(5) "Generic name." Generic name means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

(6) "Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

(a) Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.

(b) For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at five percent interest compounded annually to the end of the period selected and add this sum to the amount determined in step (a).

(c) Divide the result of step (b) (step a. for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step (b) (step a. for guaranteed cost policies) over the respective periods stipulated in step (a). If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(d) Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at five percent interest compounded annually to the end of the period stipulated in step (a) and dividing the result by the respective factors stated in step (c). (This amount is the annual premium payable for a level premium plan.)

(e) Subtract the result of step (c) from step (d).

(f) Divide the result of step (e) by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

(7) "Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

(8) "Policy summary." For the purposes of this regulation, policy summary means a written statement describing the elements of the policy including but not limited to:

(a) A prominently placed title as follows: Statement of policy cost and benefit information.

(b) The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

(c) The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

(d) The generic name of the basic policy and each rider.

(e) The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from sixty through sixty-five or maturity whichever is earlier:

(i) The annual premium for the basic policy.

(ii) The annual premium for each optional rider.

(iii) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each

optional rider, with benefits provided under the basic policy and each rider shown separately.

(iv) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(v) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(vi) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

(f) The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. (If the policy loan interest rate is variable, the policy summary shall include the maximum annual percentage rate.)

(g) Life insurance surrender cost and life insurance net payment cost indexes for ten and twenty years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor basic policies or optional riders covering more than one life.

(h) The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

(i) A policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed in addition to a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

(j) A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

(k) The date on which the policy summary is prepared. The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in item (e) of this section shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-220, filed 6/25/79, effective 1/1/80.]

WAC 284-23-230 Disclosure requirements. (1) The insurer shall provide, to all prospective purchasers, a buyer's guide and a policy summary prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least ten days or unless the policy summary contains such an unconditional refund offer, in which event the buyer's guide and policy summary must be delivered with the policy or prior to delivery of the policy. (RCW 48.23.380, requiring a 10-day free examination of policy, must be complied with.)

(2) The insurer shall provide a buyer's guide and a policy summary to any prospective purchaser upon request.

(3) In the case of policies whose equivalent level death benefit does not exceed \$5,000, the requirement for providing a policy summary will be satisfied by delivery of a written statement containing the information described in WAC 284-23-220 (8)(b), (c), (d), (e)(i), (ii) and (iii), (f), (g), (j) and (k).

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-230, filed 6/25/79, effective 1/1/80.]

WAC 284-23-240 General rules. (1) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(2) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(3) Terms such as financial planner, investment advisor, financial consultant or financial counseling shall not be used by an agent unless he is generally engaged in an advisory business and receives a material part of his compensation from that source unrelated to the sale of insurance.

(4) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(5) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(6) A presentation of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(7) A statement regarding the use of the life insurance cost indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(8) A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied

by a statement that it is based on the company's current dividend scale and is not guaranteed.

(9) For the purposes of this regulation, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-240, filed 6/25/79, effective 1/1/80.]

WAC 284-23-250 Failure to comply. Failure of an insurer to provide or deliver a buyer's guide, or a policy summary as provided in WAC 284-23-230 shall constitute an unfair method of competition and an unfair act or practice, pursuant to RCW 48.30.010.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-250, filed 6/25/79, effective 1/1/80.]

WAC 284-23-260 Effective date. This regulation, WAC 284-23-200 through 284-23-270, shall apply to all solicitations of life insurance which commence on or after January 1, 1980.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-260, filed 6/25/79, effective 1/1/80.]

WAC 284-23-270 Life insurance buyer's guide, form to be used.

(The face page of the buyer's guide shall read as follows:)

Life insurance buyer's guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)
(Month and year of printing)

(The buyer's guide shall contain the following language at the bottom of page 2:)

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this guide in making a life insurance purchase.

This guide does not endorse any company or policy.

(The remaining text of the buyer's guide shall begin on page 3 as follows:)

Buying life insurance

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by

using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the right kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

- (1) Term insurance
- (2) Whole life insurance
- (3) Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term insurance

Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some terms insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole life insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment insurance

An endowment insurance policy pays a sum or income to you—the policyholder—if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a low cost policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. Look for policies with low cost index numbers.

What is cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are cost indexes?

In order to compare the cost of policies, you need to look at:

- (1) Premiums
- (2) Cash values
- (3) Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

- (1) **Life insurance surrender cost index.** This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
- (2) **Life insurance net payment cost index.** This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

* * *

There is another number called the equivalent level annual dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's equivalent level annual dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How do I use cost indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.
- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor or a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important things to remember - A summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare surrender cost indexes and net payment cost indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. Remember, look for policies with lower cost index numbers. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you

may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-053 (Order R 79-2), § 284-23-270, filed 6/25/79, effective 1/1/80.]

ANNUITY AND DEPOSIT FUND DISCLOSURE REGULATION

WAC 284-23-300 Background. This regulation, WAC 284-23-300 through 284-23-380, is based upon the model Annuity and Deposit Fund Disclosure Regulation adopted by the National Association of Insurance Commissioners on June 16, 1978.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-300, filed 6/25/79, effective 4/1/80.]

WAC 284-23-310 Purpose. (1) The purpose of this regulation is to require insurers to deliver to prospects for annuity contracts, or for deposit funds accepted in conjunction with life insurance policies or annuity contracts, information which helps the prospect select an annuity or deposit fund, or both, appropriate to the prospect's needs, improves the prospect's understanding of the basic features of the plan under consideration and improves the prospect's ability to evaluate the relative benefits of similar plans.

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

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-310, filed 6/25/79, effective 4/1/80.]

WAC 284-23-320 Scope. (1) To the extent hereinafter provided, this regulation shall apply to any solicitation, negotiation or procurement of annuity contracts, or deposit funds accepted in conjunction with individual life insurance policies or with annuity contracts which are subject to this regulation, occurring within this state. The regulation shall apply to any issuer of life policies or annuity contracts, including fraternal mutual life insurers.

(2) This regulation shall apply to:

(a) Individual deferred annuities other than: (i) Variable annuities; (ii) investment annuities; and (iii) contracts registered with the Federal Securities and Exchange Commission.

(b) Deposit funds (i.e., arrangements under which amounts to accumulate at interest are paid in addition to life insurance premiums or annuity considerations under provisions of individual life insurance policies or annuity contracts).

(3) This regulation shall not apply to:

(a) Group annuity contracts whose cost is borne in whole or in part by the annuitant's employer or by an association of which the annuitant is a member. The cost of a contract shall not be deemed to be borne by an annuitant's

employer to the extent the annuitant's salary is reduced or the annuitant foregoes a salary increase.

(b) Immediate annuity contracts.

(c) Policies or contracts issued in connection with employee benefit plans as defined by Section 3(3) of the Federal Employee Retirement Income Security Act of 1974 (ERISA) as amended from time to time.

(d) A single advance payment of specific premiums equal to the discounted value of such premiums.

(e) A policyholder's deposit account established primarily to facilitate payment of regular premiums and where the anticipated balance of such account does not exceed twice the sum of the premiums payable in one year on all policies for which premiums are being paid from such account.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-320, filed 6/25/79, effective 4/1/80.]

WAC 284-23-330 Contract summary, contents. For the purposes of this regulation, contract summary means a written statement describing the elements of the annuity contract and deposit fund, including but not limited to:

(1) A prominently placed title as follows: Statement of benefit information. (This shall be followed by an identification of the annuity contract or deposit fund, or both, to which the statement applies.)

(2) The name and address of the insurance agent or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the contract summary.

(3) The full name and home office or administrative office address of the insurer which will issue the annuity contract or administer the deposit fund.

(4) The death benefits for the deposit fund, and for the annuity contract during the deferred period, and the form of the annuity payout. In the case where a choice of annuity payout form is provided, this item shall show the payout options guaranteed and the form of annuity payout selected for subsections (6), (7) and (9) of this section.

(5) A prominent statement that the contract does not provide cash surrender values if such is the case.

(6) The amount of the guaranteed annuity payments at the scheduled commencement of the annuity, based on the assumption that all scheduled considerations are paid and there are no prior withdrawals from or partial surrenders of the contract and no indebtedness to the insurer on the contract.

(7) On the same basis as for subsection (6) except for guarantees, illustrative annuity payments not greater in amount than those based on first, the current dividend scale and the interest rate currently used to accumulate dividends under such contracts, or the current excess interest rate credited by the insurer, and second, the current annuity purchase rates. A dividend scale or excess interest rate which has been publicly declared by the insurer with an effective date not more than two months subsequent to the date of declaration shall be considered a current dividend scale or current excess interest rate.

(8) For annuity contracts or deposit funds for which guaranteed cash surrender values at any duration are less than the total considerations paid, a prominent statement that such contractor fund may result in loss if kept for only a few

years, together with a reference to the schedule of guaranteed cash surrender values required by subsection (9)(c) of this section.

(9) The following amounts, where applicable, for the first five contract years and representative contract years thereafter sufficient to clearly illustrate the patterns of considerations and benefits, including but not limited to the tenth and twentieth contract years and at least one age from sixty through sixty-five or the scheduled commencement of annuity payments, if any, whichever is earlier:

(a) The gross annual or single consideration for the annuity contract.

(b) Scheduled annual or single deposit for the deposit fund, if any.

(c) The total guaranteed cash surrender value at the end of the year, or, if no guaranteed cash surrender values are provided, the total guaranteed paid-up annuity at the end of the year. Values for a deposit fund must be shown separately from those for a basic contract.

(d) The total illustrative cash values or paid-up annuity at the end of the year, not greater in amount than that based on first, the current dividend scale and the interest rate currently used to accumulate dividends under such contracts or the current excess interest rate credited by the insurer, and second, the current annuity purchase rates. A dividend scale or excess interest rate which has been publicly declared by the insurer with an effective date not more than two months subsequent to the date of declaration shall be considered a current dividend scale or current excess interest rate.

(10) For a contract summary which includes values based on the current dividend scale or the current dividend accumulation or excess interest rate, a statement that such values are illustrations and are not guaranteed.

(11) The date on which the contract summary is prepared.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-330, filed 6/25/79, effective 4/1/80.]

WAC 284-23-340 Contract summary, requirements. The contract summary must be a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more contract years may be represented by a single number if it is clearly indicated what amounts are applicable for each contract year. Amounts in WAC 284-23-330 (4), (6), (7) and (9) shall, in the case of flexible premium annuity contracts, be determined either according to an anticipated pattern of consideration payments or on the assumption that considerations payable will be \$1,000 per year. If not specified in the contract, annuity payments shall be assumed to commence at age 65 or 10 years from issue, whichever is later. Zero amounts shall be displayed as zero and shall not be displayed as blank spaces.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-340, filed 6/25/79, effective 4/1/80.]

WAC 284-23-350 Disclosure requirements. (1) The insurer shall provide to all prospective purchasers a contract summary prior to accepting the applicant's initial consideration for the annuity contract, or in the case of a deposit

fund, prior to acceptance of the applicant's initial consideration for the associated life insurance policy or annuity contract, unless the annuity contract or associated life insurance policy for which application is made provides for an unconditional refund period of at least ten days or unless the contract summary contains such an unconditional refund offer, in which event the contract summary must be delivered with or prior to the delivery of the annuity contract or associated life insurance policy.

(2) The insurer shall provide a contract summary to any prospective purchaser upon request.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-350, filed 6/25/79, effective 4/1/80.]

WAC 284-23-360 General rules. (1) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of at least three years following the date of its last authorized use.

(2) An agent shall inform the prospective purchaser, prior to commencing a sales presentation, that the agent is acting as a life insurance agent and shall inform the prospective purchaser of the full name of the insurance company which the agent is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(3) Terms such as financial planner, investment advisor, financial consultant, or financial counseling shall not be used by an agent unless he is generally engaged in an advisory business and receives a material part of his compensation from that source unrelated to the sale of insurance.

(4) Any reference to dividends or to excess interest credits must include a statement that such dividends or credits are not guaranteed.

(5) A presentation of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless guaranteed benefits are shown separately in close proximity thereto and with equal prominence.

(6) Sales promotion literature and contract forms shall not state or imply that annuity contracts or deposit funds are the same as savings accounts or deposits in banking or savings institutions. The use of passbooks which resemble savings bank passbooks is prohibited.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-360, filed 6/25/79, effective 4/1/80.]

WAC 284-23-370 Failure to comply. Failure of an insurer to provide or deliver a contract summary as provided in WAC 284-23-350 shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an annuity contract or of an insurance policy, and shall constitute an unfair method of competition and an unfair act or practice pursuant to RCW 48.30.010.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-370, filed 6/25/79, effective 4/1/80.]

WAC 284-23-380 Effective date. This regulation, WAC 284-23-300 through 284-23-380, shall apply to all solicitations which commence on or after April 1, 1980.

[Statutory Authority: RCW 48.02.060, 48.30.010, and 48.30.090. 79-07-052 (Order R 79-1), § 284-23-380, filed 6/25/79, effective 4/1/80.]

REPLACEMENT REGULATION

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 284-23-480 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:

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.

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.]

MISCELLANEOUS RULES

WAC 284-23-550 Relationship of death benefits to premiums—Unfair practice defined. (1) It is an unfair practice for any insurer or fraternal benefit society to provide life insurance coverage on any person through a policy or certificate of coverage delivered on or after July 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 five 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.

(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.

(6) This section does not apply to:

(a) Life insurance where the minimum death benefit is twenty-five thousand dollars or more; or

(b) Coverage under group life insurance policies unless the insured pays all or substantially all of the premium and coverage under individual conversions from such excluded policies; or

(c) Limited payment whole life insurance where the premiums are level at all times, if the least death benefit payable at any time equals or exceeds the total of all premiums which, in the absence of death, would have been paid over the entire limited payment period.

(7) This section does not apply with respect to optional additional contributions paid to the insurer or fraternal benefit society under the terms of a universal life policy, which policy:

(a) Provides a guaranteed plan of insurance of at least ten years' duration on the basis of specified premiums and complies with subsections (1) through (5) of this section; and

(b) Contains a carefully expressed provision which clearly, fairly, and fully discloses the optional plan and the choice to participate therein; and

(c) Is designed so that the charges for, and the benefits to be derived from, the optional contributions are no less favorable to the insured than those which are applicable to the guaranteed plan required by (a) of this subsection.

(8) Approval of policy forms which do not comply with this section is withdrawn.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 89-21-004 (Order R 89-12), § 284-23-550, filed 10/5/89, effective 11/5/89. Statutory Authority: RCW 48.02.060. 89-07-086 (Order R 89-4), § 284-23-550, filed 3/22/89;

89-05-017 (Order R 89-3), § 284-23-550, filed 2/9/89; 88-24-053 (Order R 88-12), § 284-23-550, filed 12/7/88.]

WAC 284-23-570 Deferred annuities with cash surrender benefits—Clarification. (1) For contracts which provide cash surrender benefits, the "maturity value of the paid-up annuity benefit," to which RCW 48.23.460 refers, shall be equal to the cash surrender value on the maturity date.

(2) On the maturity date, the cash surrender value shall be equal to the amount used to determine the annuity benefit payments. There are no surrender charges at maturity.

[Statutory Authority: RCW 48.02.060 (3)(a). 91-22-012 (Order R 91-8), § 284-23-570, filed 10/25/91, effective 11/25/91.]

ACCELERATED LIFE INSURANCE BENEFITS

WAC 284-23-600 Title. This regulation, WAC 284-23-600 through 284-23-730, inclusive, may be known and cited as "The Washington regulation on accelerated life insurance benefits."

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-600, filed 8/29/94, effective 9/29/94.]

WAC 284-23-610 Authority, finding, purpose, and scope. (1) The purpose of this regulation, WAC 284-23-600 through 284-23-730, is to define certain minimum standards for the regulation of accelerated benefit provisions of individual and group life insurance policies, a single violation of which will be deemed to constitute an unfair claims settlement practice. The commissioner finds and hereby defines it to be an unfair act or practice and an unfair method of competition for any insurer to provide accelerated benefits except as provided in this regulation.

(2) The commissioner finds that accelerated benefits in life insurance policies are primarily mortality risks rather than morbidity risks. The commissioner further finds that accelerated benefits are optional modes of settlement of proceeds under life insurance proceeds under RCW 48.11.020.

(3) This regulation applies to all accelerated benefit provisions of individual and group life insurance policies and riders which are issued or delivered to a resident of this state, on or after the effective date of this regulation. The regulation applies to both policies and riders. It also applies to solicitations for the sale of accelerated benefits, whether in the form of policies or riders.

(4) This regulation does not apply to any long term care insurance policies, contracts, or certificates.

(5) This regulation does not require inclusion or offering of any accelerated benefit in a life insurance policy. This regulation regulates those accelerated benefits which individual and group life insurers choose to advertise, offer, or market on or after the effective date of this regulation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-610, filed 8/29/94, effective 9/29/94.]

WAC 284-23-620 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this regulation.

(1) "Accelerated benefits" means benefits payable under an individual or group life insurance policy. They are primarily mortality risks, rather than morbidity risks. Accelerated benefits may also mean optional modes of settlement of proceeds under life insurance policies. Accelerated benefits are benefits:

(a) Payable to either the policyholder of an individual life policy or to the certificateholder of a group life policy, during the lifetime of the insured, in anticipation of death, or upon the occurrence of certain specified life-threatening, terminal, or catastrophic conditions defined by the policy or rider; and

(b) Which reduce or eliminate the death benefit otherwise payable under the life insurance policy or rider; and

(c) Which are payable upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time the accelerated benefit is paid.

(2) "Qualified actuary" means a person who is a qualified actuary as defined in WAC 284-05-060.

(3) "Qualifying event" means one or more of the following:

(a) A medical condition which would result in a drastically limited life span as specified in the policy or rider, such as twenty-four months or less;

(b) A medical condition which has required or requires extraordinary medical intervention; for example, major organ transplants or the use of continuous life support, without which the insured would die;

(c) Any condition which usually requires continuous confinement in any eligible institution as defined in the policy or rider, if the insured is expected to remain there for the rest of his or her life;

(d) Any medical condition which, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span of the insured. Such medical conditions may include, for example:

(i) Coronary artery disease resulting in an acute infarction or requiring surgery;

(ii) Permanent neurological deficit resulting from cerebral vascular accident;

(iii) End stage renal failure;

(iv) Acquired immune deficiency syndrome; or

(v) Other medical conditions which the insurance commissioner approves for any particular filing.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-620, filed 8/29/94, effective 9/29/94.]

WAC 284-23-630 Assignees and beneficiaries. Prior to the payment of any accelerated benefit, the insurer shall obtain from any assignee or irrevocable beneficiary a signed consent to the terms of the payout. If the insurer paying the accelerated benefit is itself an assignee, its own written consent is not required.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-630, filed 8/29/94, effective 9/29/94.]

WAC 284-23-640 Criteria for payment. (1) Payment options shall include, the option of taking the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

(2) No insurer may restrict the use of the proceeds from the payment of accelerated benefits.

(3) If any part of the death benefit remains after payment of an accelerated benefit, then any applicable accidental death benefit payable under the policy or rider shall not be affected by the payment of the accelerated benefit.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-640, filed 8/29/94, effective 9/29/94.]

WAC 284-23-650 Disclosure statement. (1) The words "accelerated benefit" must be included in the required title of every life insurance policy or rider that includes a provision for accelerated benefits. Accelerated benefits shall not be described, advertised, marketed, or sold as either long-term care insurance or as providing long-term care benefits.

(2) Possible tax consequences and possible consequences on eligibility for receipt of Medicare, Medicaid, Social Security, Supplemental Security Income (SSI), or other sources of public funding shall be included in every disclosure statement.

(a) A disclosure statement shall be provided which contains a statement that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related materials.

(b) The disclosure statement shall contain substantially the following: "If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy."

(c) The disclosure statement must be provided (i) to the applicant for an individual or group life insurance policy at the time application is made for the policy or rider; and (ii)(A) to the individual insured at the time the owner of an individual life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid, or (B) to the individual certificateholder at the time an individual certificateholder of a group life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid. It is not sufficient to provide this required disclosure statement only to the holder of a group policy.

(3) The disclosure statement shall give a brief and clear description of the accelerated benefit. It shall define all qualifying events which can trigger payment of the accelerated benefit. It shall also describe any effect of payment of accelerated benefits upon the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the disclosure form to the applicant before or at the time the application is signed. Written acknowledge-

ment of receipt of the disclosure statement shall be signed by the applicant and the agent.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a written notice that a full premium refund shall be made if the policy is returned to the insurer within the free look period.

(c) In the case of group life insurance policies, the disclosure statement shall be contained in the certificate of coverage, or in any other related document furnished by the insurer to the certificateholder.

(4) If there is a premium or cost of insurance charge for the accelerated benefit, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of an accelerated benefit upon the policy's cash value, accumulation account, death benefit, premium, policy loans, or policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant either before or at the time the application is signed.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant concurrently with delivery of the policy to the applicant.

(c) In the case of group life insurance policies, the disclosure form shall be included in the certificate of insurance or any related document furnished by the insurer to the certificateholder.

(5)(a) Insurers with financing options other than as described in WAC 284-23-690 (1)(b) and (c) of this regulation, shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. Insurers shall make a reasonable effort to assure that the certificateholder on a group policy is made aware of any premium or cost of insurance charge for the accelerated benefits, if he or she is required to pay all or any part of such a premium or cost of insurance charge.

(b) Insurers shall furnish an actuarial demonstration to the Insurance Commissioner when filing an individual or group life insurance policy or rider form that provides accelerated benefits, showing the method used to calculate the cost for the accelerated benefit.

(6) Insurers shall disclose to the policyholder any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificateholder on a group policy is made aware of any administrative expense charge if he or she is required to pay all or any part of any such charge.

(7) When the owner of an individual policy or the certificateholder of a group policy requests payment of an accelerated benefit, within 20 days of receiving the request the insurer shall send a statement to that person, and to any irrevocable beneficiary, showing any effect that payment of an accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. This statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. When the insurer pays the accelerated benefit, it shall issue an amended schedule page to the owner of an individual policy, or to the certificateholder of a group policy, showing any new, reduced in-force amount

of the policy. When more than one payment of accelerated benefit is permitted under the policy or rider, the insurer shall send a revised statement to the owner of an individual policy, or to the certificateholder of a group policy, when a previous statement has become invalid due to payment of accelerated benefits.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 94-24-072 (Order R 94-25), § 284-23-650, filed 12/6/94, effective 1/6/95. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-650, filed 8/29/94, effective 9/29/94.]

WAC 284-23-660 Effective date of the accelerated benefit. The accelerated benefit provision shall be effective for accidents on the effective date of the policy or rider. The accelerated benefit provision shall be effective for illness no more than thirty days following the effective date of the policy or rider.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-660, filed 8/29/94, effective 9/29/94.]

WAC 284-23-670 Waiver of premiums. The insurer may offer a waiver of premium for the accelerated benefit provision, even in the absence of a policy waiver of premium provision being in effect. At the time payment of the accelerated benefit is requested, the insurer shall explain to the owner of an individual policy, or the certificateholder of a group policy, any continuing premium requirement necessary to keep the policy in force.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-670, filed 8/29/94, effective 9/29/94.]

WAC 284-23-680 Unfair discrimination. An insurer shall not unfairly discriminate between insureds with different qualifying events covered under the policy or rider. An insurer may not unfairly discriminate between insureds with similar or identical qualifying events covered under the policy or rider. Insurers may not apply conditions on the payment of the accelerated benefits except those specified in the insured's policy or rider.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-680, filed 8/29/94, effective 9/29/94.]

WAC 284-23-690 Actuarial standards, financing options, effect on cash value, and effect on policy loans.

(1) An insurer shall select one of the following finance options. Under subsection (1)(a) and (1)(b) of this section, the accelerated death benefit is regarded as completely settled. Premiums, if any, payable for the remaining coverage shall be reduced proportionally.

(a) An insurer may require a premium charge or cost of insurance charge for the accelerated benefit. These charges shall be based on sound actuarial principles. No additional charges may be imposed to collect benefits.

(b) An insurer may pay the present value of the face amount of the insured's policy or certificate. The calculation of that present value shall be based upon any applicable discount appropriate to the policy design. The interest rate or interest rate methodology used in the calculation shall be based upon sound actuarial principles and disclosed in the policy or actuarial memorandum. The maximum interest rate used shall be no more than the greater of:

- (i) The current yield on ninety day treasury bills; or
- (ii) The current maximum statutory adjustable policy loan interest rate.

(c) An insurer may accrue an interest charge on the amount of the accelerated benefits. The interest rate or the interest rate methodology used in the calculation shall be based upon sound actuarial principles and shall be disclosed in the policy or the actuarial memorandum. The maximum interest rate used shall be no more than the greater of:

- (i) The current yield on ninety day treasury bills; or
- (ii) The current maximum statutory adjustable policy loan interest rate.

The interest rate accrued on the portion of the lien which is equal in amount to the cash value of the policy at the time the benefit is accelerated shall be no more than the loan interest rate stated in the policy.

(2) When an accelerated benefit is payable, there shall be no more than a pro rata reduction in the cash value based upon the percentage of death benefit accelerated to produce the accelerated benefit payment; provided, however, that the payment of accelerated benefits, any administrative expense charges, any future premiums, and any accrued interest may be considered a lien against the death benefit of the policy or rider, and the access to any remaining cash value may be restricted to the excess of the cash value over the sum of any other outstanding loans and any lien. Future access to additional policy loans may be limited to any excess of the cash value over the sum of the lien and any other outstanding policy amounts. When payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment may not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 94-24-072 (Order R 94-25), § 284-23-690, filed 12/6/94, effective 1/6/95. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-690, filed 8/29/94, effective 9/29/94.]

WAC 284-23-700 Actuarial disclosure and reserves.

(1) A qualified actuary shall describe the accelerated benefits, the risks, the expected costs, and the calculation of statutory reserves in an actuarial memorandum accompanying each filing that includes a provision for accelerated benefits. The insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

(2)(a) When benefits are provided through the acceleration of benefits under individual or group life policies, or riders to such policies, policy reserves shall be determined in accordance with the Standard Valuation Law chapter 48.74 RCW. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a qualified actuary. Mortality tables and interest currently recognized for life insurance reserves by the National Association of Insurance Commissioners may be used, as well as appropriate assumptions for the other provisions incorporated in the policy. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate shall be sufficient to cover:

- (i) Policies upon which no claim has yet arisen; and

(ii) Policies upon which a claim for one or more payments of accelerated benefits has arisen.

(b) For policies and certificates which provide actuarially equivalent benefits, no additional reserves need to be established.

(c) Policy liens and policy loans, plus any accrued interest, represent assets of the insurer for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability, such excess must be held as a non-admitted asset.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-700, filed 8/29/94, effective 9/29/94.]

WAC 284-23-710 Filing requirements. The filing of all forms containing accelerated benefit provisions, including both policies and riders, is required, pursuant to RCW 48.18.100 and WAC 284-58-130.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-710, filed 8/29/94, effective 9/29/94.]

WAC 284-23-720 Administrative expenses. All charges or fees for administration or processing requests for any payments of accelerated benefits shall be disclosed and fully described in the policy, rider, and disclosure statement. Any such charge or fee shall be reasonable; shall be assessed no more than once; and may not exceed five hundred dollars.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-720, filed 8/29/94, effective 9/29/94.]

WAC 284-23-730 Resolution of disputes regarding occurrence of qualifying events. (1) In the event the insured's health care provider and a health care provider appointed by the insurer disagree on whether a qualifying event has occurred, the opinion of the health care provider appointed by the insurer is not binding on the claimant. The parties shall attempt to resolve the matter promptly and amicably. The policy or rider providing the accelerated benefit shall provide that in case the disagreement is not so resolved, the claimant has the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either party. Any such arbitration shall be conducted in accordance with chapter 7.04 RCW. As part of the final decision, the arbitrator or mediator shall award the costs of arbitration to one party or the other or may divide the costs equally or otherwise.

(2) To select the arbitrator or mediator, the claimant shall choose one health care provider, who may or may not be the claimant's regular health care provider or otherwise associated with or related to the claimant. The insurer shall choose one health care provider, who may or may not be an employee or otherwise associated with the insurer. Those two choices shall be made within seven days after the later of those two health care providers has been chosen, those two health care providers shall agree on and appoint an arbitrator or mediator. The arbitrator or mediator will hear the case or otherwise commence resolving it within seven days of his or her appointment, and shall render a decision within fourteen days after appointment.

(3) "Health care provider," as used in this regulation, means a health care provider acting within the scope of his or her license.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 94-18-029 (Order R 94-18), § 284-23-730, filed 8/29/94, effective 9/29/94.]

Chapter 284-24 WAC RATES

WAC

284-24-015	Statistical plans and designation of statistical agents.
284-24-060	Modification of filing requirements.
284-24-065	Demonstration that rates satisfy the requirements of RCW 48.19.020.
284-24-070	Suspension of filing requirements—"(A)" rating.
284-24-080	Rate filings required for certain inland marine risks.
284-24-100	Standards for schedule rating plans, noncomplying filings ineffective.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-24-010	Statistical plans—Reporting loss and expense experience. [General Bulletin, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-020	Organizations designated as statistical agents. [General Bulletin, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-030	Nonsubscribing and nonmember carriers—Duties. [General Bulletin, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-035	Exempt insurance carriers. [General Bulletin of 5/1/49, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-040	Allocating indivisible premiums—"Homeowners policies." [Rule made 11/30/55, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-050	Catastrophe coverage. [Rule made 7/23/51, filed 3/22/60.] Repealed by 82-06-036 (Order R 82-1), filed 3/1/82. Statutory Authority: RCW 48.02.060.
284-24-055	Fifteen-month refiling requirement. [Statutory Authority: RCW 48.02.060, 48.19.080 and 48.19.370. 90-13-041 (Order R 90-5), § 284-24-055, filed 6/14/90, effective 7/15/90.] Repealed by 94-20-059, filed 9/30/94, effective 10/30/94. Statutory Authority: RCW 48.02.060.

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

(1) The statistical plans of the Insurance Services Office, Inc. with respect to the following kinds of insurance:

- (a) Fire and allied lines,
- (b) Automobile physical damage,
- (c) Automobile liability,
- (d) General liability,
- (e) Burglary,
- (f) Glass,
- (g) Boiler and machinery,
- (h) Inland marine,

(i) Homeowners, comprehensive dwelling and dwelling policy program,

- (j) Commercial multiperil,
- (k) Businessowners, and
- (l) Professional liability.

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

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

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

- (a) Homeowners,
- (b) Farmowners,
- (c) Mobile homeowners,
- (d) Inland marine,
- (e) Farm fire,
- (f) Dwelling fire,
- (g) Commercial fire,
- (h) General liability,
- (i) Burglary,
- (j) Glass,
- (k) Commercial multiperil,
- (l) Manufacturers output, and
- (m) Businessowners.

(4) The statistical plan of the Surety Association of America with respect to fidelity, surety and forgery.

(5) The statistical plan of the National Crop Insurance Services with respect to hail insurance on growing crops and windstorm (when accompanied by hail) insurance on growing crops.

(6) The statistical plan of the Factory Mutual Service Bureau with respect to property insurance.

(7) The statistical plan of the Mill and Elevator Rating Bureau with respect to property insurance.

(8) The statistical plan of the Nuclear Insurance Rating Bureau with respect to nuclear physical damage insurance.

Experience filed by individual carriers is to be kept confidential by these statistical agents and only the consolidated experience will be available as public information.

[Statutory Authority: RCW 48.02.060, 48.19.080 and 48.19.370. 90-13-041 (Order R 90-5), § 284-24-015, filed 6/14/90, effective 7/15/90. Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-015, filed 3/1/82.]

WAC 284-24-060 Modification of filing requirements. (1) Pursuant to RCW 48.19.080, the commissioner rules and hereby orders that the rate filing requirements set forth in chapter 48.19 RCW are modified so that:

(a) No filings with respect to rates pertaining to surplus line coverages placed in this state pursuant to chapter 48.15

RCW need be made, hereby confirming the longstanding practice in this state; and

(b) Rating organizations may make reference filings of prospective loss costs. Such filings shall contain the statistical data and supporting information for all calculations and assumptions underlying the prospective loss costs, but need not provide the information required by RCW 48.19.040 (2)(b) and (c). Filings of prospective loss costs must be approved by the commissioner prior to use by any insurer as a reference document. A member or subscribing insurer must file a loss cost adjustment and obtain the commissioner's approval prior to use of rates based on prospective loss costs.

A member or subscribing insurer of a rating organization may use rates based on prospective loss costs filed by such an organization and approved by the commissioner as a reference document without complying with the requirements of RCW 48.19.040 if:

(i) The insurer has an approved loss cost adjustment on file with the commissioner and proposes no changes to it; and

(ii) The insurer will begin using the prospective loss costs on the date proposed by the rating organization and approved by the commissioner.

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

(a) "Rating organization" means an organization licensed pursuant to RCW 48.19.180.

(b) "Member or subscribing insurer" means an insurer that has granted filing authority to a rating organization pursuant to RCW 48.19.050.

(c) "Prospective loss cost" means that portion of a rate that provides only for losses and loss adjustment expense and does not include provisions for expenses (other than loss adjustment expenses) or profit, and is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

(d) "Loss cost adjustment" means a factor by which prospective loss costs are multiplied to obtain final rates. It takes into account:

(i) Operating expenses;

(ii) Underwriting profit (or loss) and contingencies;

(iii) Investment income;

(iv) Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers;

(v) Variations in loss experience unique to the insurer making the filing;

(vi) The effect of the timing difference on the prospective loss costs in those instances in which an insurer elects to begin using prospective loss costs on a date other than that proposed by the rating organization and approved by the commissioner; and

(vii) Other relevant factors, if any.

(e) "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or separately as prospective loss cost and loss cost adjustment, prior to any application of individual risk variations as permitted by WAC 284-24-100, and does not include minimum premiums or supplementary rating information.

(f) "Supplementary rating information" means any manual or plan of policy writing rules, rating rules, classification system, territory codes and descriptions, rating plans, and any other similar information needed to determine the applicable premium for an insured. It includes factors and relativities, such as increased limits factors, package modification factors, classification relativities, and deductible relativities.

[Statutory Authority: RCW 48.02.060. 94-20-059, § 284-24-060, filed 9/30/94, effective 10/31/94. Statutory Authority: RCW 48.02.060, 48.19.080 and 48.19.370. 90-13-041 (Order R 90-5), § 284-24-060, filed 6/14/90, effective 7/15/90. Statutory Authority: RCW 48.02.060 (3)(e), 86-24-043 (Order R 86-7), § 284-24-060, filed 11/26/86. Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-060, filed 3/1/82.]

WAC 284-24-065 Demonstration that rates satisfy the requirements of RCW 48.19.020. (1) RCW 48.19.020 requires that premium rates for insurance shall not be excessive, inadequate, or unfairly discriminatory. A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer. Such costs include claims, claim settlement expenses, operational and administrative expenses, and the cost of capital. When an insurer or rating organization files rates with the commissioner, it must demonstrate how it has accounted for each of these costs, so that the commissioner can determine whether the proposed rates satisfy the requirements of RCW 48.19.020.

(2) An insurer filing rates must demonstrate that it has accounted for the cost of capital by showing that its expected after-tax return on equity is consistent with its expected cost of capital. A rating organization filing rates must demonstrate that it has accounted for the cost of capital by showing that its members' or subscribers' expected after-tax return on equity is consistent with their expected cost of capital. An insurer or rating organization may establish the expected cost of capital by citing:

(a) Data pertaining to historical after-tax returns on equity for the property-casualty insurance industry as a whole; or

(b) Data pertaining to historical after-tax returns on equity for insurers writing coverages involving a similar level of risk; or

(c) Data pertaining to historical after-tax returns on equity for other industries involving a similar level of risk; or

(d) In the case of a stock insurer, data pertaining to the after-tax return on equity necessary to attract and retain investors; or

(e) In the case of a mutual or reciprocal insurer, data pertaining to the after-tax return on equity necessary to maintain policyholders' surplus adequate to support the insurer's business.

(3) For the purposes of this section, equity shall customarily be computed under generally accepted accounting principles. However, at the rate filer's option, insurers' statutory surplus as regards policyholders may be used instead. The equity assigned to the writing of a particular coverage in this state shall be determined by making a reasonable allocation of total equity by coverage and by

state. Allocation of equity by coverage may involve a recognition of the differences in the level of risk by coverage.

(4) The expected after-tax return shall include:

(a) Expected underwriting profit or loss; and

(b) Expected investment income, including, but not limited to, investment income on assets corresponding to unearned premium reserves, loss and loss adjustment expense reserves, and statutory surplus as regards policyholders; and

(c) Other expected income, at the filer's option; and

(d) Expected federal income taxes arising from (a), (b), and (c) of this subsection, including, but not limited to, taxes due to the revenue offset, reserve discounting, and alternative minimum tax provisions of the Tax Reform Act of 1986.

(5) Due to the variability of expected realized and unrealized capital gains and taxes thereon, the commissioner will not require that these items be included in the expected after-tax return for ratemaking purposes.

(6) Expected after-tax return on equity shall be determined as the annualized rate of return arising from policies to be written in the period during which the filing is expected to be in effect. The calculations involved should follow from the methods used in preparing the filing.

(7) In lieu of allocating its equity as prescribed by subsection (3) of this section, an insurer may establish a target operating ratio applicable to all coverages. For the purposes of this section, "operating ratio" is the sum of after-tax underwriting profit (or loss) and after-tax investment income on assets corresponding to unearned premium reserves and loss and loss adjustment expense reserves, divided by premium. The insurer must show that its target operating ratio corresponds to an expected after-tax return on equity that is consistent with its cost of capital, in accordance with subsection (2) of this section. Although investment income on assets corresponding to policyholders' surplus is not included in the calculation of an operating ratio, this component of investment income must be considered in establishing the target operating ratio, because it must be included in the expected after-tax return on equity, in accordance with subsection (4) of this section.

(8) For liability insurance, if the increased limits factors include risk loads, the proportion of the expected premium (net of expenses) arising from the risk loads for all policy limits shall be included in the expected underwriting profit or loss.

(9) So that the commissioner may more easily determine whether rates satisfy the requirements of RCW 48.19.020:

(a) The use of the word "indicated" in a rate filing to describe a rate or rate change shall be limited to situations in which:

(i) The insurer or rating organization making the filing has taken into account all of the factors listed in RCW 48.19.030 (3)(a) through (f); and

(ii) The rate or rate change labeled "indicated" corresponds to an expected after-tax return on equity which is supported as required by subsection (2) of this section.

(b) A rate filing must contain an explanation of any material difference between an indicated rate or rate change and a proposed rate or rate change.

(10) Filings of supplementary rating information, as defined by WAC 284-24-060 (2)(f), are exempt from the

requirements of this section. However, if package modification factors are not supported by data showing the relationship between package and monoline loss experience and expenses, the requirements of this section apply to filings of package modification factors.

(11) The requirements of this section shall apply to all rate filings received by the commissioner after April 30, 1991.

[Statutory Authority: RCW 48.02.060 and 48.19.080. 91-01-073 (Order R 90-13), § 284-24-065, filed 12/17/90, effective 1/17/91.]

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

(a) Covering risks in a class, which risks are so different from each other that no single manual rate could be representative of all,

(b) Covering risks of a classification that does not develop enough experience to warrant any creditability for ratemaking purposes, or

(c) Covering risks that involve a new product or coverage as to which there is no appropriate analogy to similar exposures for ratemaking purposes.

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

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

(a) Specific definable loss potential characteristics,

(b) Analogy to similar exposures, and

(c) Available loss frequency and severity data.

(4) Examples of appropriate "(a)" rated risks include but are not limited to:

(a) Manufacturing and construction risks, such as:

(i) Ammunition manufacturing,

(ii) Dam construction,

(iii) Irrigation works operation, and

(iv) Logging railroad—operation and maintenance.

(b) Owners, landlord and tenants risks, such as:

(i) Amusement devices, designed for small children only, not otherwise classified (NOC),

(ii) Christmas tree lots—open air,

(iii) Bleachers or grandstands,

(iv) Dude ranches,

(v) Firing ranges—indoor,

(vi) Parks or playgrounds, and

(vii) Zoos.

(c) Product risks, such as:

(i) Aircraft or aircraft parts manufacturing,

(ii) Ball or roller bearing manufacturing,

(iii) Chemical manufacturing—household—NOC,

(iv) Discontinued operations—products,

(v) Electronic component manufacturing,

(vi) Firearms manufacturing—over .50 caliber

(vii) Instrument manufacturing—NOC,

(viii) Levee construction,

- (ix) Machinery or machinery parts manufacturing,
- (x) Pharmaceutical or surgical goods manufacturing,
- (xi) Products—NOC,
- (xii) Sign manufacturing—NOC,
- (xiii) Tank manufacturing—metal—not pressurized,
- (xiv) Textile coating or impregnating,
- (xv) Tool manufacturing—hand type—powered,
- (xvi) Valves manufacturing,
- (xvii) Wheels manufacturing,
- (xviii) Wire goods manufacturing—NOC, and
- (xix) Wood products manufacturing—NOC.

(5) Insurers writing "(a) rated risks" shall maintain separate documentation, including loss experience, on each risk written and shall be prepared to provide such documentation to the insurance commissioner upon request.

[Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-070, filed 3/1/82.]

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

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

- (30) Travel baggage (issued in combination with accident and sickness insurance),
- (31) Wedding presents, and
- (32) Boatowners' and/or boats under twenty-seven feet in length.

[Statutory Authority: RCW 48.02.060 (3)(e). 86-24-043 (Order R 86-7), § 284-24-080, filed 11/26/86. Statutory Authority: RCW 48.02.060. 82-06-036 (Order R 82-1), § 284-24-080, filed 3/1/82.]

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

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

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

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

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

(b) Condition and upkeep of premises and equipment.

(c) Location of risk and suitability of occupancy.

(d) Quality of fire and police protection.

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

(f) Type of equipment.

(g) Safety programming.

(h) Construction features and maintenance.

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

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

(5) A plan shall be administered equitably and applied fairly to every eligible risk which an insurer elects to insure. Records supporting the development of individual risk modifications shall be retained by the insurer for a minimum of three years or until the conclusion of the next regular examination conducted by the insurance department of its domicile, whichever is later, and made available at all reasonable times for the commissioner's examination. Such records must include copies of all documentation used in making each particular determination, even though a credit or debit may not result.

[Statutory Authority: RCW 48.02.060, 48.19.080 and 48.19.370. 90-13-041 (Order R 90-5), § 284-24-100, filed 6/14/90, effective 7/15/90. Statutory Authority: RCW 48.02.060. 85-23-031 (Order R 85-4), § 284-24-100, filed 11/14/85.]

Chapter 284-26 WAC

INSIDER TRADING OF EQUITY SECURITIES OF A DOMESTIC STOCK INSURANCE COMPANY

WAC

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284-26-210	Exemption from RCW 48.08.130 of certain transactions effected in connection with a distribution.
284-26-220	Exemption from RCW 48.08.130 of sales of securities to be acquired.
284-26-230	Arbitrage transactions under RCW 48.08.150.

WAC 284-26-010 Definition of certain terms. (1)

"Insurer" means any domestic stock insurance company with an equity security subject to the provisions of sections 6 through 13, chapter 70, Laws of 1965 ex. sess., codified as RCW 48.08.100 through 48.08.170, and not exempt thereunder.

(2) "Act" means sections 6 through 13, chapter 70, Laws of 1965 ex. sess., codified as RCW 48.08.100 through 48.08.170.

(3) "Officer" means a president, vice-president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

(4) "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for such a security; or any security convertible, with or without consideration, into such a security, or carrying

any warrant or right to subscribe to or purchase such a security; or any such warrant or right.

(5) Securities "held of record."

(a) For the purpose of determining whether the equity securities of an insurer are held of record by one hundred or more persons, securities shall be deemed to be "held of record" by each person who is identified as the owner of such securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(i) In any case where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as such an owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

(ii) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person.

(iii) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person.

(iv) Securities held by two or more persons as co-owners shall be included as held by one person.

(v) Each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if such securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of persons.

(vi) Securities registered in substantially similar names where the insurer has reason to believe because of the address or other indications that such names represent the same person, may be included as held of record by one person.

(b) Notwithstanding subsection (a) of this section:

(i) Securities held, to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in such securities; provided however, that the insurer may rely in good faith on such information as is received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest.

(ii) If the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the act, the beneficial owners of such securities shall be deemed to be the record owners thereof.

(iii) "Class" means all securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

[Order R-69-3, § 284-26-010, filed 2/7/69.]

WAC 284-26-020 Transactions exempted from the operation of RCW 48.08.120. Any acquisition or disposition of any equity security by a director or officer of an insurer within six months prior to the date on which the act

shall first become applicable with respect to the equity securities of such insurer shall not be subject to the operation of RCW 48.08.120.

[Order R-69-3, § 284-26-020, filed 2/7/69.]

WAC 284-26-030 Filing of statements. Initial statements of beneficial ownership of equity securities required by RCW 48.08.110 shall be filed on Form S, to be obtained from the commissioner. Statements of changes in such beneficial ownership required by RCW 48.08.110 shall be filed on Form 4, to be obtained from the commissioner. All such statements shall be prepared and filed in accordance with the requirements of the applicable form.

[Order R-69-3, § 284-26-030, filed 2/7/69.]

WAC 284-26-040 Ownership of more than ten percent of an equity security. In determining for the purpose of RCW 48.08.110 whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of equity securities, such person shall be deemed to be the beneficial owner of securities of such class which such person has the right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. The securities subject to such options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, in accordance with WAC 284-26-030, the percentage of outstanding securities of the class owned by such person but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This paragraph shall not be construed to relieve any person of any duty to comply with RCW 48.08.110 with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section of the act.

[Order R-69-3, § 284-26-040, filed 2/7/69.]

WAC 284-26-050 Disclaimer of beneficial ownership. Any person filing a statement may expressly declare therein that the filing of such statement shall not be construed as an admission that such person is, for the purpose of the act, the beneficial owner of any equity securities covered by the statement.

[Order R-69-3, § 284-26-050, filed 2/7/69.]

WAC 284-26-060 Exemptions from RCW 48.08.110 and 48.08.120. (1) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from RCW 48.08.110 and 48.08.120:

(a) Executors or administrators of the estate of a decedent;

(b) Guardians or committees for an incompetent; and

(c) Receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(2) After the twelve-month period following their appointment or qualification the foregoing persons shall be

required to file reports with respect to the securities held by the estates which they administer under RCW 48.08.110 and shall be liable for profits realized from trading in such securities pursuant to RCW 48.08.120 only when the estate being administered is a beneficial owner of more than ten per cent of any class of equity security of an insurer subject to the act.

(3) Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from RCW 48.08.110 and 48.08.120 during the time they are held by the insurer.

[Order R-69-3, § 284-26-060, filed 2/7/69.]

WAC 284-26-070 Exemption from the act of securities purchased or sold by odd-lot dealers. Securities purchased or sold by an odd-lot dealer (1) in odd lots so far as reasonably necessary to carry on odd-lot transactions or (2) in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business, shall be exempt from the provisions of the act with respect to participation by such odd-lot dealer in such transactions.

[Order R-69-3, § 284-26-070, filed 2/7/69.]

WAC 284-26-080 Certain transactions subject to RCW 48.08.110. The acquisition or disposition of any transferable option, put, call, spread or straddle shall be deemed such a change in the beneficial ownership of the security to which such privilege relates as to require the filing of a statement reflecting the acquisition or disposition of such privilege. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of such option, put, call, spread or straddle.

[Order R-69-3, § 284-26-080, filed 2/7/69.]

WAC 284-26-090 Ownership of securities held in trust. (1) Beneficial ownership of a security for the purpose of RCW 48.08.110 shall include:

(a) The ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust,

(b) The ownership of a vested beneficial interest in a trust, and

(c) The ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(2) Except as provided in subsection (3) hereof, a beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of RCW 48.08.110 where less than twenty percent in market value of the securities having a readily ascertainable market value held by such trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from RCW 48.08.110 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of such securities by the trust is made without prior approval by the settlor or beneficiary. No exemption

pursuant to this subsection shall, however, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of RCW 48.08.110.

(3) In the event that ten percent of any class of any equity security of an insurer is held in a trust, that trust and the trustees thereof as such shall be deemed a person required to file the reports specified in RCW 48.08.110.

(4) Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors or ten percent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of all trustees, settlors and beneficiaries who are officers, directors or ten per cent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file any such report so long as he relies in good faith upon an understanding that the trustee of such trust will file whatever reports might otherwise be required of such beneficiary.

(5) As used in this section the "immediate family" of a trustee means:

(a) A son or daughter of the trustee, or a descendant of either,

(b) A stepson or stepdaughter of the trustee,

(c) The father or mother of the trustee, or an ancestor of either,

(d) A stepfather or stepmother of the trustee,

(e) A spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of such person by blood.

(6) In determining, for the purposes of RCW 48.08.110 whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of any equity security, the interest of such person in the remainder of a trust shall be excluded from the computation.

(7) No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under RCW 48.08.110 with respect to his indirect interest in portfolio securities held by:

(a) A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(b) A business trust with over 25 beneficiaries.

(8) Nothing in this section shall be deemed to impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date.

[Order R-69-3, § 284-26-090, filed 2/7/69.]

WAC 284-26-100 Exemption for small transactions.

(1) Any acquisition of securities shall be exempt from RCW 48.08.110 where:

(a) The person effecting the acquisition does not within six months thereafter effect any disposition, otherwise than by way of gift, or securities of the same class, and

(b) The person effecting such acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of

\$3,000 for any six months' period during which the acquisition occurs.

(2) Any acquisition or disposition of securities by way of gift where the total amount of such gifts does not exceed \$3,000 in market value for any six months' period, shall be exempt from RCW 48.08.110 and may be excluded from the computations prescribed in subdivision (1)(b).

(3) Any person exempted by subsection (1) or (2) of this section shall include in the first report filed by him after a transaction within the exemption a statement showing his acquisitions and dispositions for each six months' period or portion thereof which has elapsed since his last filing.

[Order R-69-3, § 284-26-100, filed 2/7/69.]

WAC 284-26-110 Exemption from RCW 48.08.120 of transactions which need not be reported under RCW 48.08.110. Any transaction which has been or shall be exempted from the requirements of RCW 48.08.110 of the act shall, insofar as it is otherwise subject to the provisions of RCW 48.08.120 be likewise exempted from RCW 48.08.120.

[Order R-69-3, § 284-26-110, filed 2/7/69.]

WAC 284-26-120 Exemption from RCW 48.08.120 of certain transactions effected in connection with a distribution. (1) Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of RCW 48.08.120, to the extent specified in this section as not comprehended within the purpose of RCW 48.08.120, upon the following conditions:

(a) The person effecting the transaction is engaged in the business of distributing securities and is participating in good faith, in the ordinary course of such business, in the distribution of such block of securities;

(b) The security involved in the transaction is (i) a part of such block of securities and is acquired by the person effecting the transaction, with a view to the distribution thereof, from the insurer or other person on whose behalf such securities are being distributed or from a person who is participating in good faith in the distribution of such block of securities or (ii) a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed or to cover an over-allotment or other short position created in connection with such distribution; and

(c) Other persons not within the purview of RCW 48.08.120 are participating in the distribution of such block of securities on terms at least as favorable as those on which such person is participating and to an extent at least equal to the aggregate participation of all persons exempted from the provisions of RCW 48.08.120 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

(2) The exemption of a transaction pursuant to this section with respect to the participation therein of one party thereto shall not render such transaction exempt with respect

to participation of any other party therein unless such other party also meets the conditions of this section.

[Order R-69-3, § 284-26-120, filed 2/7/69.]

WAC 284-26-130 Exemption from RCW 48.08.120 of acquisitions of shares of stock and stock options under certain stock bonus, stock option or similar plans. Any acquisition of shares of stock (other than stock acquired upon the exercise of an option, warrant or right) pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan, by a director or officer of an insurer issuing such stock or stock option shall be exempt from the operation of RCW 48.08.120 if the plan meets the following conditions:

(1) The plan has been approved, directly or indirectly, (a) by the affirmative votes of the holders of a majority of the securities of such insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the state of Washington, or (b) by the written consent of the holders of a majority of the securities of such insurer entitled to vote: *Provided, however,* that if such vote or written consent was not solicited substantially in accordance with the proxy rules and regulations prescribed by the National Association of Insurance Commissioners, if any, in effect at the time of such vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by any such rules and regulations so prescribed and in effect at the time such information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of (i) the date the act first applies to such insurer, or (ii) the acquisition of an equity security for which exemption is claimed. Such written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of such written information shall be filed with, or mailed for filing to, the commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this paragraph, the term "insurer" includes a predecessor corporation if the plan or obligations to participate thereunder were assumed by the insurer in connection with the succession.

(2) If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to any such director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any such director or officer, is subject to the discretion of any person, then such discretion shall be exercised only as follows:

(a) With respect to the participation of directors—

(i) By the board of directors of the insurer, a majority of which board and a majority of the directors action in the matter are disinterested persons;

(ii) By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, all of the members of which committee are disinterested persons; or

(iii) Otherwise in accordance with the plan, if the plan (a) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, such stock may be acquired or such options may be acquired and exercised; or (b) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors.

(b) With respect to the participation of officers who are not directors—

(i) By the board of directors of the insurer or a committee of three or more directors; or

(ii) By, or only in accordance with the recommendations of, a committee of three or more persons having full authority to set in the matter, all of the members of which committee are disinterested persons.

For the purpose of this paragraph, a director or committee member shall be deemed to be a disinterested person only if such person is not at the time such discretion is exercised eligible and has not at any time within one year prior thereto been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan or any other plan of the insurer or any of its affiliates entitling the participants therein to acquire stock or qualified, restricted or employee stock purchase plan stock options of the insurer or any of its affiliates.

(c) The provisions of this section shall not apply with respect to any option granted, or other equity security acquired, prior to the date that RCW 48.08.110, 48.08.120, and 48.08.130 first become applicable with respect to any class of equity securities of any insurer.

(3) As to each participant or as to all participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date; and may be determined either by fixed or maximum dollar amounts or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages thereof outstanding from time to time, or similar factors which will result in an effective and determinable limitation. Such limitations may be subject to any provisions for adjustment of the plan or of stock

allocable or options outstanding thereunder to prevent dilution or enlargement of rights.

(4) Unless the context otherwise requires, all terms used in this section shall have the same meaning as in the act and in WAC 284-26-110. In addition, the following definitions apply:

(a) The term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

(b) The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in section 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section, provided however, that for the purposes of this section an option which meets all of the conditions of that section, other than the date of issuance shall be deemed to be a "restricted stock option."

(c) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this section shall not include (i) the making of any election to receive under any plan an award of compensation in the form of stock or credits therefore, provided, that such election is made prior to the making of the award; and provided further that such election is irrevocable until at least six months after termination of employment; (ii) the subsequent crediting of such stock; (iii) the making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery; (iv) the fulfillment of any condition to the absolute right to receive such stock; or (v) the acceptance of certificates for shares of such stock.

[Order R-69-3, § 284-26-130, filed 2/7/69.]

WAC 284-26-140 Exemption from RCW 48.08.120 of certain transactions in which securities are received by redeeming other securities. Any acquisition of an equity security (other than [than] a convertible security or right to purchase a security) by a director or officer of the insurer issuing such security shall be exempt from the operation of RCW 48.08.120 upon condition that:

(1) The equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets other than cash (or government bonds) consist of securities of the insurer issuing the equity security so acquired, and which

(a) Represented substantially and in practical effect a stated or readily ascertainable amount of such equity security,

(b) Had a value which was substantially determined by the value of such equity security, and

(c) Conferred upon the holder the right to receive such equity security without the payment of any consideration other than the security redeemed;

(2) No security of the same class as the security redeemed was acquired by the director or officer within six months prior to such redemption or is acquired within six months after such redemption;

(3) The insurer issuing the equity security acquired has recognized the applicability of subsection (1) of this section by appropriate corporate action.

[Order R-69-3, § 284-26-140, filed 2/7/69.]

WAC 284-26-150 Exemption of long-term profits incident to sales within six months of the exercise of an option. (1) To the extent specified in subsection (2) of this section, the commissioner hereby exempts as not comprehended within the purposes of RCW 48.08.120 any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where such purchase is pursuant to the exercise of an option or similar right either (a) acquired more than six months before its exercise, or (b) acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

(2) In respect of transactions specified in subsection (1) the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this section shall be deemed to enlarge the amount of profit which would inure to such insurer in the absence of this section.

(3) The commissioner also hereby exempts, as not comprehended within the purposes of RCW 48.08.120 the disposition of a security, purchased in a transaction specified in subsection (1) of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in section 368(c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of such plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(4) The exemptions proved by this section shall not apply to any transaction made unlawful by RCW 48.08.130 or by any rules and regulations thereunder.

(5) The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption.

[Order R-69-3, § 284-26-150, filed 2/7/69.]

WAC 284-26-160 Exemption from RCW 48.08.120 of certain acquisitions and dispositions of securities pursuant to merger or consolidations. (1) The following transactions shall be exempt from the provisions of RCW 48.08.120 as not comprehended within the purpose of said section:

(a) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(b) The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to said merger or

consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(c) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation;

(d) The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to said merger or consolidation, held over 85 percent of the combined assets of all the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a twelve-month period prior to the merger or consolidation.

(2) A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

(3) Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this section) of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by this section shall be unavailable to such officer, director, or stockholder to the extent of such purchase and sale.

[Order R-69-3, § 284-26-160, filed 2/7/69.]

WAC 284-26-170 Exemption from RCW 48.08.120 of transactions involving the deposit or withdrawal of equity securities under a voting trust or deposit agreement. Any acquisition or disposition of an equity security involved in the deposit of such security under, or the withdrawal of such security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing such security, shall be exempt from the operation of RCW 48.08.120 if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn: *Provided, however,* that this section shall not apply to the extent that there shall have been either:

(1) A purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or

(2) A sale of an equity security of the class deposited and purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction

exempted by any other provision of chapter 284-26 WAC within a period of less than six months which includes the date of the deposit or withdrawal.

(3) The surrender and issuance are made pursuant to provisions of a certificate of incorporation which require that the shares issued upon such surrender shall be registered upon issuance in the name of a person or persons other than the holder of the shares surrendered and may be required to be issued as of right only in connection with the public offering, sale and distribution of such shares and the immediate sale by such holder of such shares for that purpose, or in connection with a gift of such shares.

(4) Neither the shares so surrendered nor any shares of the same class, nor other shares of the same class as those issued upon such surrender, have been or are purchased (otherwise than in a transaction exempted by this section), by the person surrendering such shares, within six months before or after such surrender or issuance.

[Order R-69-3, § 284-26-170, filed 2/7/69.]

WAC 284-26-180 Exemption from RCW 48.08.120 of certain transactions involving the conversion of equity securities. (1) Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of RCW 48.08.120: *Provided, however,* That this section shall not apply to the extent that there shall have been either (a) a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or (b) a sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in such conversion or in a transaction exempted by any other provision of chapter 284-26 WAC) within a period of less than six months which includes the date of conversion.

(2) For the purpose of this section, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with such conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(3) For the purpose of this section, an equity security shall be deemed convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

[Order R-69-3, § 284-26-180, filed 2/7/69.]

WAC 284-26-190 Exemption from RCW 48.08.120 of certain transactions involving the sale of subscription rights. (1) Any sale of a subscription right to acquire any subject security of the same insurer shall be exempt from the provisions of RCW 48.08.120, to the extent prescribed in

this section, as not comprehended with the purpose of RCW 48.08.120, if:

(a) Such subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(b) Such subscription right by its terms expires within 45 days after the issuance thereof;

(c) Such subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(d) A registration statement under the Securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from such registration have been met in respect to each subject security.

(2) When used within this section the following terms shall have the meaning indicated:

(a) The term "subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(b) The term "beneficiary security" means a security registered pursuant to section 12 of the Securities Exchange Act, to the holders of which a subscription right is granted;

(c) The term "subject security" means a security which is the subject of a subscription right.

(3) Notwithstanding anything contained herein to the contrary, if a person purchases subscription rights for cash or other consideration, then a sale by such person of subscription rights otherwise exempted by this section will not be so exempted to the extent of such purchases within the six-month period preceding or following such sale.

[Order R-69-3, § 284-26-190, filed 2/7/69.]

WAC 284-26-200 Exemption of certain securities from RCW 48.08.130. Any security shall be exempt from the operation of RCW 48.08.130 to the extent necessary to render lawful under RCW 48.08.130 the execution by a broker of an order for an account in which he has no direct or indirect interest.

[Order R-69-3, § 284-26-200, filed 2/7/69.]

WAC 284-26-210 Exemption from RCW 48.08.130 of certain transactions effected in connection with a distribution. Any security shall be exempt from the operation of RCW 48.08.130 to the extent necessary to render lawful under such section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

(1) The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset such sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

(2) Other persons not within the purview of RCW 48.08.130 are participating in the distribution of such block of securities on terms at least as favorable as those on which such dealer is participating and to an extent at least equal to the aggregate participation of all persons exempted from the

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provisions of RCW 48.08.130 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing such functions shall not preclude an exemption which would otherwise be available under this section.

[Order R-69-3, § 284-26-210, filed 2/7/69.]

WAC 284-26-220 Exemption from RCW 48.08.130 of sales of securities to be acquired. (1) Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of RCW 48.08.130 provided that:

(a) The sale is made subject to the same conditions as those attaching to the right of acquisition, and

(b) Such person exercises reasonable diligence to deliver such security to the purchaser promptly after his right of acquisition matures, and

(c) Such person reports the sale on the appropriate form for reporting transactions by persons subject to RCW 48.08.110.

(2) This section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

[Order R-69-3, § 284-26-220, filed 2/7/69.]

WAC 284-26-230 Arbitrage transactions under RCW 48.08.150. It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of such insurer, unless he shall include such transaction in the statements required by RCW 48.08.110 and shall account to such insurer for the profits arising from such transaction, as provided in RCW 48.08.120. The provisions of RCW 48.08.130 shall not apply to such arbitrage transactions. The provisions of the act shall not apply to any bona fide foreign or domestic arbitrage transaction insofar as it is effected by any person other than such director or officer of the insurer.

[Order R-69-3, § 284-26-230, filed 2/7/69.]

Chapter 284-28 WAC

PROXIES, CONSENTS, AND AUTHORIZATIONS OF DOMESTIC STOCK INSURERS

WAC

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284-28-110 Effective date.

WAC 284-28-001 Promulgation. Whereas, subsection (7), section 5, chapter 70, Laws of 1965 ex. sess. provides:

"The commissioner shall have authority to make and promulgate rules and regulations for the effectuation of this section, and in so doing shall give due consideration to rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states." and,

Whereas, pursuant to RCW 34.04.020(3) a rule-making hearing was held on the fifteenth day of September, 1965, at the hour of 1:30 p.m. in the Office of the Insurance Commissioner, Insurance Building, Olympia, Washington, to receive views as to whether the above-entitled regulation should be adopted,

Now, therefore, I hereby make the following findings:

(1) On June 8, 1964, the Congress of the United States enacted the Securities Act Amendments of 1964 (Public Law 88-467) which exempts securities issued by an insurance company from the application of the federal requirement of regulation by, and periodic filings with, the Securities Exchange Commission provided that the following conditions are met:

"(I) . . .

(II) Such insurance company is subject to regulation by its domiciliary State of proxies, consents, or authorizations in respect of securities issued by such company and such regulation conforms to that prescribed by the National Association of Insurance Commissioners.

"(III) . . ."

(2) The above-entitled regulation substantially conforms to the proposals regarding proxies, consents and authorizations of domestic stock insurers as prescribed and promulgated by the National Association of Insurance Commissioners on the third day of December, 1964.

(3) The above-entitled regulation reasonably effectuates section 5, chapter 70, Laws of 1965 ex. sess., by making the regulation of domestic stock insurers with respect to proxies, consents and authorizations complete when applied in conjunction with section 5, chapter 70, Laws of 1965 ex. sess.

Now, therefore, being fully informed, I hereby adopt the following order and regulation upon the foregoing findings and pursuant to subsection (7), section 5, chapter 70, Laws of 1965 ex. sess.

[Order R-69-2, § 284-28-001, filed 2/5/69; Regulation 246, filed 9/24/65, effective 11/1/65.]

WAC 284-28-010 Application of regulation. This regulation is applicable to each domestic stock insurer which has any class of equity security held of record by one hundred or more persons; provided, however, that this regulation shall not apply to any insurer if ninety-five percent or more of its equity securities are owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than five hundred persons. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the

applicable regulations promulgated thereunder, shall be exempt from the provisions of this regulation with respect to any class of securities subject to SEC jurisdiction.

[Order R-69-2, § 284-28-010, filed 2/5/69; Regulation 246, § 1, filed 9/24/65, effective 11/1/65.]

WAC 284-28-020 Proxies, consents, and authorizations. No domestic stock insurer, or any director, officer or employee of such insurer subject to WAC 284-28-010, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent of authorization in respect of any class of equity security of such insurer held of record by one hundred or more persons in contravention of this regulation and Schedules A and B hereto annexed and hereby made a part of this regulation.

[Order R-69-2, § 284-28-020, filed 2/5/69; Regulation 246, § 2, filed 9/24/65, effective 11/1/65.]

WAC 284-28-030 Disclosure of equivalent information. Unless proxies, consents or authorizations in respect of any class of equity security of a domestic insurer subject to WAC 284-28-010 are solicited by or on behalf of the management of such insurer from the holders of record of such security prior to any annual or other meeting of such security holders, such insurer shall, in accordance with this regulation and such further regulations as the commissioner may adopt, file with the commissioner and transmit to all security holders of record information substantially equivalent to the information which would be required to be transmitted if a solicitation were made. Such insurer shall transmit a written information statement containing the information specified in WAC 284-28-050(4) to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited on behalf of the management of the insurer provided, that in the case of a class of securities in unregistered or bearer form such statement need be transmitted only to those security holders whose names and addresses are known to the insurer.

[Order R-69-2, § 284-28-030, filed 2/5/69; Regulation 246, § 3, filed 9/24/65, effective 11/1/65.]

WAC 284-28-040 Definitions. (1) The definitions and instructions set out in Schedule SIS of the insurer's annual statement required to be filed pursuant to RCW 48.05.250, shall be applicable for purposes of this regulation.

(2) The terms "solicit" and "solicitation" for purposes of this regulation shall include:

(a) Any request for a proxy, whether or not accompanied by or included in a form of proxy; or

(b) Any request to execute or not to execute, or to revoke, a proxy; or

(c) The furnishing of a proxy or other communication to stockholders under circumstances reasonably calculated to result in the procurement, withholding or revocation of a proxy.

(3) The terms "solicit" and "solicitation" shall not include:

(a) Any solicitation by a person in respect of stock of which he is the beneficial owner;

(b) Action by a broker or other person in respect to stock carried in his name or in the name of his nominee in forwarding to the beneficial owner of such stock soliciting material received from the company, or impartially instructing such beneficial owner to forward a proxy to the person, if any, to whom the beneficial owner desires to give a proxy, or impartially requesting instructions from the beneficial owner with respect to the authority to be conferred by the proxy and stating that a proxy will be given if the instructions are received by a certain date;

(c) The furnishing of a form of proxy to a stockholder upon the unsolicited request of such stockholder, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

[Order R-69-2, § 284-28-040, filed 2/5/69; Regulation 246, § 4, filed 9/24/65, effective 11/1/65.]

WAC 284-28-050 Information to be furnished to stockholders. (1) No solicitation subject to this regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

(2) If the solicitation is made on behalf of the management of the insurer and relates to an annual meeting of stockholders at which directors are to be elected, each proxy statement furnished pursuant to subsection one hereof shall be accompanied or preceded by an annual report (in preliminary or final form) to such stockholders containing such financial statements for the last fiscal year as are referred to in Schedule SIS of the insurers annual statement under the heading "financial reporting to the stockholders." Subject to the foregoing requirements with respect to financial statements, the annual report to stockholders may be in any form deemed suitable by the management.

(3) Two copies of each report sent to the stockholders pursuant to this section shall be mailed to the commissioner, not later than the date on which such report is first sent or given to stockholders or the date on which preliminary copies of solicitation material are filed with the commissioner, pursuant to WAC 284-28-070(1), whichever date is later.

(4) If no solicitation is being made by management of the insurer with respect to any annual or other meeting, such insurer shall mail to every security holder of record at least twenty days prior to the meeting date, an information statement as required by WAC 284-28-030, containing the information called for by all of the Items of Schedule A, other than Items 1, 3, and 4 thereof, which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting. If such information statement relates to an annual meeting at which directors are to be elected, it shall be accompanied by an annual report to such security holders in the form provided in subsection 2 thereof.

[Order R-69-2, § 284-28-050, filed 2/5/69; Regulation 246, § 5, filed 9/24/65, effective 11/1/65.]

WAC 284-28-060 Requirements as to proxy, and information statement. (1) The form of proxy (a) shall indicate in boldface type whether or not the proxy is solicited on behalf of the management, (b) shall provide a

specifically designated blank space for dating the proxy and (c) shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the management, or stockholders. No reference need be made to proposals as to which discretionary authority is conferred pursuant to subsection three hereof.

(2)(a) Means shall be provided in the proxy for the person solicited to specify by ballot a choice between approval or disapproval of each matter or group of related matters referred to therein, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified if the form of proxy states in boldface type how it is intended to vote the shares or authorization represented by the proxy in each such case.

(b) A form of proxy which provides both for elections to office and for action on other specified matters shall be prepared so as to clearly provide, by a box or otherwise, means by which the security holder may withhold authority to vote for elections to office. Any such form of proxy which is executed by the security holder in such manner as not to withhold authority to vote for elections to office shall be deemed to grant such authority, provided the form of proxy so states in boldface type.

(3) A proxy may confer discretionary authority with respect to other matters which may come before the meeting, provided the persons on whose behalf the solicitation is made are not aware a reasonable time prior to the time the solicitation is made that any other matters are to be presented for action at the meeting and provided further that a specific statement to that effect is made in the proxy statement or in the form of proxy.

(4) No proxy shall confer authority (a) to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or (b) to vote at any annual meeting other than the next annual meeting (or any adjournment thereof) to be held after the date on which the proxy statement and form of proxy are first sent or given to stockholders.

(5) The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the proxy will be voted and that where the person solicited specifies by means of ballot provided pursuant to subsection two hereof a choice with respect to any matter to be acted upon, the vote will be in accordance with the specifications so made.

(6) The information included in the proxy statement or information statement shall be clearly presented and the statements made shall be divided into groups according to subject matter, with appropriate headings. All printed proxy statements or information statements shall be clearly and legibly presented.

[Order R-69-2, § 284-28-060, filed 2/5/69; Regulation 246, § 6, filed 9/24/65, effective 11/1/65.]

WAC 284-28-070 Material required to be filed. (1) Two preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to stockholders concurrently therewith shall be filed with the commissioner at least ten days prior to the date definitive copies of such material are first sent or given to stockhold-

ers, or such shorter period prior to that date as the commissioner may authorize upon a showing of good cause therefor.

(2) Two preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to stockholders subsequent to the proxy statements shall be filed with the commissioner at least two days (exclusive of Saturdays, Sundays or holidays) prior to the date copies of this material are first sent or given to stockholders or a shorter period prior to such date as the commissioner may authorize upon a showing of good cause therefor.

(3) Two definitive copies of the proxy statement, form of proxy and all other soliciting material, in the form in which this material is furnished to stockholders, shall be filed with, or mailed for filing to, the commissioner not later than the date such material is first sent or given to the stockholders.

(4) Where any proxy statement, form of proxy or other material filed pursuant to these rules is amended or revised, two of the copies shall be marked to clearly show such changes.

(5) Copies of replies to inquiries from stockholders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this section.

(6) Notwithstanding the provisions of subsections one and two hereof and of subsection five of WAC 284-28-100, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the commissioner prior to use or publication. Definitive copies, however, shall be filed with or mailed for filing to the commissioner as required by subsection three hereof not later than the date such material is used or published. The provisions of subsections one and two hereof and subsection five of WAC 284-28-100 shall apply, however, to any reprints or reproductions of all or any part of such material.

[Order R-69-2, § 284-28-070, filed 2/5/69; Regulation 246, § 7, filed 9/24/65, effective 11/1/65.]

WAC 284-28-080 False or misleading statements.

No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this regulation, shall contain any statement which at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

[Order R-69-2, § 284-28-080, filed 2/5/69; Regulation 246, § 8, filed 9/24/65, effective 11/1/65.]

WAC 284-28-090 Prohibition of certain solicitations. No person making a solicitation which is subject to this regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the stockholder.

[Order R-69-2, § 284-28-090, filed 2/5/69; Regulation 246, § 9, filed 9/24/65, effective 11/1/65.]

WAC 284-28-100 Special provisions applicable to election contests. (1) **Applicability.** This section shall apply to any solicitation subject to this regulation by any person or group for the purpose of opposing a solicitation subject to this regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of stockholders.

(2) **Participant or participant in a solicitation.** (a) For purposes of this section the terms "participant" and "participant in a solicitation" include: (i) The insurer; (ii) any director of the insurer, and any nominee for whose election as a director proxies are solicited; (iii) any other person, acting alone or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

(b) For the purposes of this section the terms "participant" and "participant in a solicitation" do not include: (i) A bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of stock and who is not otherwise a participant; (ii) any person or organization retained or employed by a participant to solicit stockholders or any person who merely transmits proxy soliciting material or performs ministerial or clerical duties; (iii) any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment; (iv) any person regularly employed as an officer or employee of the insurer or any of its subsidiaries or affiliates who is not otherwise a participant; or (v) any officer or director of, or any person regularly employed by any other participant, if such officer, director, or employee is not otherwise a participant.

(3) **Filing of information required by Schedule B.** (a) No solicitation subject to this section shall be made by any person other than the management of an insurer unless at least five business days prior thereto, or such shorter period as the commissioner may authorize upon a showing of good cause therefor, there has been filed, with the commissioner, by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to stockholders in furtherance of such solicitation. Where preliminary copies of any materials are filed, distribution to stockholders should be deferred until the Commissioner's comments have been received and complied with.

(b) Within five business days after a solicitation subject to this section is made by the management of an insurer, or such longer period as the commissioner may authorize upon a showing of good cause therefor, there shall be filed with the commissioner by or on behalf of each participant in such solicitation, other than the insurer, and by or on behalf of each management nominee for director, a statement in duplicate containing the information specified by Schedule B.

(c) If any solicitation on behalf of management or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this section in opposition thereto, a statement in duplicate containing the

information specified in Schedule B shall be filed with the commissioner, by or on behalf of each participant in such prior solicitation, other than the insurer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

(d) If, subsequent to the filing of the statements required by paragraphs (a), (b) and (c) of this subsection, additional persons become participants in a solicitation subject to this rule, there shall be filed with the commissioner, by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the commissioner may authorize upon a showing of good cause therefor.

(e) If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the commissioner.

(f) Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the commissioner.

(4) Solicitations prior to furnishing required written proxy statement. Notwithstanding the provisions of subsection one of WAC 284-28-050, a solicitation subject to this section may be made prior to furnishing stockholders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that—

(a) The statements required by subsection three hereof are filed by or on behalf of each participant in such solicitation.

(b) No form of proxy is furnished to stockholders prior to the time the written proxy statement required by subsection one of WAC 284-28-050 is furnished to such persons: *Provided, however,* That this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to stockholders.

(c) At least the information specified in paragraphs (b) and (c) of the statements required by subsection three hereof to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to stockholders in connection with the solicitation.

(d) A written proxy statement containing the information specified in Schedule A with respect to a solicitation is sent or given stockholders at the earliest practicable date.

(5) Solicitations prior to furnishing required written proxy statement—Filing requirements. Two copies of any soliciting material proposed to be sent or given to stockholders prior to the furnishing of the written proxy statement required by subsection one of WAC 284-28-050 shall be filed with the commissioner in preliminary form at least five business days prior to the date definitive copies of such material are first sent or given to such persons, or shorter period as the commissioner may authorize upon a showing of good cause therefor.

(6) Application of this section to report. Notwithstanding the provisions of subsections two and three of WAC 284-28-050, two copies of any portion of the report referred to in subsection two of WAC 284-28-050 which comments upon or refers to any solicitation subject to this section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with

the commissioner as proxy material subject to this regulation. Such portion of the report shall be filed with the commissioner in preliminary form at least five business days prior to the date copies of the report are first sent or given to stockholders.

SCHEDULE A

INFORMATION REQUIRED IN PROXY STATEMENT

Item 1. Revocability of proxy. State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

Item 2. Dissenters' rights of appraisal. Outline briefly the rights of appraisal or similar rights of dissenting stockholders with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by such stockholders in order to perfect their rights. Where such rights may be exercised only within a limited time after the date of the adoption of a proposal, the filing of a charter amendment, or other similar act, state whether the person solicited will be notified of such date.

Item 3. Persons making solicitations not subject to (WAC 284-28-100). (1) If the solicitation is made by the management of the insurer, so state. Give the name of any director of the insurer who has informed the management in writing that he intends to oppose any action intended to be taken by the management and indicate the action which he intends to oppose.

(2) If the solicitation is made otherwise than by the management of the insurer, state the names and addresses of the persons by whom and on whose behalf it is made and the names and addresses of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

(3) If the solicitation is to be made by specially engaged employees or paid solicitors, state (i) the material features of any contract or arrangement for such solicitation and identify the parties, and (ii) the cost or anticipated cost thereof.

Item 4. Interest of certain persons in matters to be acted upon. Describe briefly any substantial interest, direct or indirect, by stockholdings or otherwise, of any director, nominee for election for director, officer and, if the solicitation is made otherwise than on behalf of management, each person on whose behalf the solicitation is made, in any matter to be acted upon other than elections to office.

Item 5. Stocks and principal stockholders. (1) State, as to each class of voting stock of the insurer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

(2) Give the date as of which the record list of stockholders entitled to vote at the meeting will be determined. If the right to vote is not limited to stockholders of record on that date, indicate the conditions under which other stockholders may be entitled to vote.

(3) If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights, make a statement that they have such rights and state briefly the conditions precedent to the exercise thereof.

Item 6. Nominee and directors. If action is to be taken with respect to the election of directors furnish the

following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each other person whose term of office as a director will continue after the meeting:

(a) Name each such person, state when his term of office or the term of office for which he is a nominee will expire, and all other positions and offices with the insurer presently held by him, and indicate which persons are nominees for election as directors at the meeting.

(b) State his present principal occupation or employment and give the name and principal business of any corporation or other organization in which such employment is carried on. Furnish similar information as to all of his principal occupations or employments during the last five years, unless he is now a director and was elected to his present term of office by a vote of stockholders at a meeting for which proxies were solicited under this regulation.

(c) If he is or has previously been a director of the insurer, state the period or periods during which he has served as such.

(d) State, as of the most recent practicable date, the approximate amount of each class of stock of the insurer or any of its parents, subsidiaries or affiliates other than directors' qualifying shares, beneficially owned directly or indirectly by him. If he is not the beneficial owner of any such stocks make a statement to that effect.

Item 7. Remuneration and other transactions with management and others. Furnish the information reported or required in item one of Schedule SIS under the heading "Information regarding management and directors" if action is to be taken with respect to (a) the election of directors, (b) any remuneration plan, contract or arrangement in which any director, nominee for election as a director, or officer of the insurer will participate, (c) any pension or retirement plan in which any such person will participate, or (d) the granting or extension to any such person of any options, warrants or rights to purchase any stocks, other than warrants or rights issued to stockholders, as such, on a pro-rata basis. If the solicitation is made on behalf of persons other than the management information shall be furnished only as to item one-A of the aforesaid heading of Schedule SIS.

Item 8. Bonus, profit sharing and other remuneration plans. If action is to be taken with respect to any bonus, profit sharing, or other remuneration plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) The amounts which would have been distributable under the plan during the last calendar year to (1) each person named in item seven of this schedule, (2) directors and officers as a group, and (3) to all other employees as a group, if the plan had been in effect.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in paragraph (b) of this item, the nature of such amendments should be specified.

Item 9. Pension and retirement plan. If action is to be taken with respect to any pension or retirement plan of the insurer, furnish the following information:

(a) A brief description of the material features of the plan, each class of persons who will participate therein, the approximate number of persons in each such class, and the basis of such participation.

(b) State (1) the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid, and the estimated annual payments necessary to pay the total amount over such period; (2) the estimated annual payment to be made with respect to current services; and (3) the amount of such annual payments to be made for the benefit of (i) each person named in item seven of this schedule, (ii) directors and officers as a group, and (iii) employees as a group.

(c) If the plan to be acted upon may be amended (other than by a vote of stockholders) in a manner which would materially increase the cost thereof to the insurer or to materially alter the allocation of the benefits as between the groups specified in sub-paragraph (b)(3) of this item, the nature of such amendments should be specified.

Item 10. Options, warrants, or rights. If action is to be taken with respect to the granting or extension of any options, warrants or rights (all referred to herein as "warrants") to purchase stock of the insurer or any subsidiary or affiliate, other than warrants issued to all stockholders on a pro-rata basis, furnish the following information:

(a) The title and amount of stock called for or to be called for, the prices, expiration dates and other material conditions upon which the warrants may be exercised, the consideration received or to be received by the insurer, subsidiary or affiliate for the granting or extension of the warrants and the market value of the stock called for or to be called for by the warrants, as of the latest practicable date.

(b) If known, state separately the amount of stock called for or to be called for by warrants received or to be received by the following person, naming each such person:

(1) Each person named in item seven of this schedule, and

(2) Each other person who will be entitled to acquire five per cent or more of the stock called for or to be called for by such warrants.

(c) If known, state also the total amount of stock called for or to be called for by such warrants, received or to be received by all directors and officers of the company as a group and all employees, without naming them.

Item 11. Authorization or issuance of stock. 1. If action is to be taken with respect to the authorization or issuance of any stock of the insurer furnish the title, amount and description of the stock to be authorized or issued.

2. If the shares of stock are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

3. If the shares of stock to be authorized or issued are other than additional shares of common stock of a class outstanding, the Commissioner may require financial

statements comparable to those contained in the annual report.

Item 12. Mergers, consolidations, acquisitions and similar matters. 1. If action is to be taken with respect to a merger, consolidation, acquisition, or similar matter, furnish in brief outline the following information:

(a) The rights of appraisal or similar rights of dissenters with respect to any matters to be acted upon. Indicate any procedure required to be followed by dissenting stockholders in order to perfect such rights.

(b) The material features of the plan or agreement.

(c) The business done by the company to be acquired or whose assets are being acquired.

(d) If available, the high and low sales prices for each quarterly period within two years.

(e) The percentage of outstanding shares which must approve the transaction before it is consummated.

2. For each company involved in a merger, consolidation or acquisition, the following financial statements should be furnished:

(a) A comparative balance sheet as of the close of the last two fiscal years.

(b) A comparative statement of operating income and expenses for each of the last two fiscal years and, as a continuation of each statement, a statement of earning per share after related taxes and cash dividends paid per share.

(c) A pro forma combined balance sheet and income and expenses statement for the last fiscal year giving effect to the necessary adjustments with respect to the resulting company.

Item 13. Restatement of accounts. If action is to be taken with respect to the restatement of any asset, capital, or surplus of the insurer, furnish the following information:

(a) State the nature of the restatement and the date as of which it is to be effective.

(b) Outline briefly the reasons for the restatement and for the selection of the particular effective date.

(c) State the name and amount of each account affected by the restatement and the effect of the restatement thereon.

Item 14. Matters not required to be submitted. If action is to be taken with respect to any matter which is not required to be submitted to a vote of stockholders, state the nature of such matter, the reason for submitting it to a vote of stockholders and what action is intended to be taken by the management in the event of a negative vote on the matter by the stockholders.

Item 15. Amendment of charter, bylaws, or other documents. If action is to be taken with respect to any amendment of the insurer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment and the vote needed for its approval.

SCHEDULE B

INFORMATION TO BE INCLUDED IN STATES FILED BY
OR ON BEHALF OF A PARTICIPANT (OTHER THAN
THE INSURER) IN A PROXY SOLICITATION IN AN
ELECTION CONTEST

Item 1. Insurer. State the name and address of the insurer.

Item 2. Identity and background. (a) State the following:

(1) Your name and business address.

(2) Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

(b) State the following:

(1) Your residence address.

(2) Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

(c) State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

(d) State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.

Item 3. Interest in securities of the insurer. (a) State the amount of each class of stock of the insurer which you own beneficially, directly or indirectly.

(b) State the amount of each class of stock of the insurer which you own of record but not beneficially.

(c) State with respect to all securities of the insurer purchased or sold within the past two years, the dates on which they were purchased or sold and the amount purchased or sold on each such date.

(d) If any part of the purchase price or market value of any of the stock specified in paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such stock, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

(e) State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any stock of the insurer, including but not limited to joint ventures, loan or option arrangements, puts or calls, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. If so name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.

(f) State the amount of stock of the insurer owned beneficially, directly or indirectly, by each of your associates and the name and address of each such associate.

(g) State the amount of each class of stock of any parent, subsidiary or affiliate of the insurer which you own beneficially, directly or indirectly.

Item 4. Further matters. (a) Describe the time and circumstances under which you became a participant in the

solicitation and state the nature and extent of your activities or proposed activities as a participant.

(b) Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

(c) State whether or not you or any of your associates have any arrangement or understanding with any person—

(1) With respect to any future employment by the insurer or its subsidiaries or affiliates; or

(2) With respect to any future transactions to which the insurer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangements or understanding and state the names of the parties thereto.

Item 5. **Signature.** The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

.....
 (Date) (Signature of participant or authorized representative)

[Order R-69-2, § 284-28-100, filed 2/5/69; Regulation 246, § 10, filed 9/24/65, effective 11/1/65.]

WAC 284-28-110 Effective date. This regulation is effective on the first day of November, 1965.

[Order R-69-2, § 284-28-110, filed 2/5/69; Regulation 246, filed 9/24/65, effective 11/1/65.]

**Chapter 284-30 WAC
 TRADE PRACTICES**

WAC

UNFAIR CLAIMS SETTLEMENT PRACTICES

- 284-30-300 Authority and purpose.
- 284-30-310 Scope.
- 284-30-320 Definitions.
- 284-30-330 Specific unfair claims settlement practices defined.
- 284-30-340 File and record documentation.
- 284-30-350 Misrepresentation of policy provisions.
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- 284-30-370 Standards for prompt investigation of claims.
- 284-30-380 Standards for prompt, fair and equitable settlements applicable to all insurers.
- 284-30-390 Standards for prompt, fair and equitable settlements applicable to automobile insurance.
- 284-30-400 Enforcement.
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- 284-30-450 Insurance policies and contracts—Coverage for drugs.

TRADE PRACTICES

- 284-30-500 Unfair practices with respect to vehicle insurance.
- 284-30-550 Receipts to be given.
- 284-30-560 Applications and binders.
- 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed.
- 284-30-572 Discrimination prohibited.

- 284-30-574 Insurer must make independent evaluation.
- 284-30-580 Policies to be delivered, not held by agents.
- 284-30-590 Unfair practices with respect to policy cancellations, renewals, and changes.
- 284-30-600 Unfair practices with respect to out-of-state group life and disability insurance.
- 284-30-610 Unfair practices with respect to the solicitation of coverage under out-of-state group policies.
- 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.
- 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations.
- 284-30-750 Brokers' fees to be disclosed.
- 284-30-800 Unfair practices applicable to title insurers and their agents.

**DISPOSITION OF SECTIONS FORMERLY
 CODIFIED IN THIS CHAPTER**

- 284-30-005 Which regulation applicable. [Order R-71-1, § 284-30-005, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-010 Replacement of life insurance policies. [Order R-68-10, § 284-30-010, filed 10/25/68; Order R-68-1 (part), § 284-30-010, filed 4/23/68, effective 10/1/68.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-100 Title and explanation. [Order R-71-1, § 284-30-100, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-110 Purpose. [Order R-71-1, § 284-30-110, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-120 Replacement of life insurance defined. [Order R-71-1, § 284-30-120, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-130 Exemptions. [Order R-71-1, § 284-30-130, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-140 Duties of licensees. [Order R-71-1, § 284-30-140, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-150 Duties of insurers. [Order R-71-1, § 284-30-150, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-160 Enforcement. [Order R-71-1, § 284-30-160, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-170 Forms. [Order R-71-1, § 284-30-170, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-180 Supersedes prior regulation. [Order R-71-1, § 284-30-180, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-190 Severability. [Order R-71-1, § 284-30-190, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-200 Effective date. [Order R-71-1, § 284-30-200, filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.
- 284-30-990 Exhibit 1—Disclosure statement. [Exhibit 1 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-990), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

284-30-991 Exhibit 2—Notice to applicants regarding replacement of life insurance. [Exhibit 2 is part of Washington Administrative Code Order R-71-1 (codified as WAC 284-30-991), filed 6/15/71, effective 9/1/71.] Repealed by 81-18-038 (Order R 81-4), filed 8/28/81. Statutory Authority: RCW 48.02.060.

UNFAIR CLAIMS SETTLEMENT PRACTICES

WAC 284-30-300 Authority and purpose. RCW 48.30.010 authorizes the commissioner to define methods of competition and acts and practices in the conduct of the business of insurance which are unfair or deceptive. The purpose of this regulation, WAC 284-30-300 through 284-30-410, is to define certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-300, filed 7/27/78, effective 9/1/78.]

WAC 284-30-310 Scope. This regulation applies to all insurers and to all insurance policies and insurance contracts. This regulation is not exclusive, and acts performed, whether or not specified herein, may also be deemed to be violations of specific provisions of the insurance code or other regulations.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-310, filed 7/27/78, effective 9/1/78.]

WAC 284-30-320 Definitions. When used in this regulation:

(1) "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

(2) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(3) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(4) "Insurance policy" or "insurance contract" mean any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer;

(5) "Insurer" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal mutual insurer, fraternal mutual life insurer, and any other legal entity engaged in the business of insurance, authorized or licensed to issue or who issues any insurance policy or insurance contract in this state. "Insurer" does not include health care service contractors, as defined in RCW 48.44.010, and health maintenance organizations, as defined in RCW 48.46.020;

(6) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(7) "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and

(8) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-320, filed 7/27/78, effective 9/1/78.]

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 284-30-340 File and record documentation.

The insurer's claim files shall be subject to examination by the commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-340, 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 284-30-360 Failure to acknowledge pertinent communications.

(1) Every insurer, upon receiving notification of a claim shall, within ten working days, or 15 working days with respect to claims arising under group insurance contracts, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) Every insurer, upon receipt of any inquiry from the office of the insurance commissioner respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(3) An appropriate reply shall be made within ten working days, or 15 working days with respect to communications arising under group insurance contracts, on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section shall constitute compliance with that subsection.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-360, filed 7/27/78, effective 9/1/78.]

WAC 284-30-370 Standards for prompt investigation of claims. Every insurer shall complete investigation

of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time. All persons involved in the investigation of a claim shall provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.]

WAC 284-30-380 Standards for prompt, fair and equitable settlements applicable to all insurers. (1) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within forty-five days from the date of the initial notification and no later than every thirty days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(4) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(6) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-380, 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 284-30-400 Enforcement. Violations of the standards imposed by WAC 284-30-330 through 284-30-390 shall be subject to the enforcement provisions set forth in RCW 48.30.010 and shall also constitute a failure to comply with a regulation pursuant to RCW 48.05.140(1).

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-400, filed 7/27/78, effective 9/1/78.]

WAC 284-30-410 Effective date. This regulation, WAC 284-30-300 through 284-30-410, shall take effect September 1, 1978.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-410, filed 7/27/78, effective 9/1/78.]

WAC 284-30-450 Insurance policies and contracts—Coverage for drugs. (1) Authority and purpose.

(a) Some insurers deny payment for drugs that have been approved by the Federal Food and Drug Administration (FDA) when the drugs are used for indications other than those stated in the labelling approved by the FDA (off-label use) while other insurers with similar coverage terms pay for off-label use. Denial of payment for off-label use can

interrupt or effectively deny access to necessary and appropriate treatment for a person being treated for a life-threatening illness.

(b) Equity among insured residents of this state and fair claims settlement practices and fair competition among companies providing coverage to residents of this state require comparable reimbursement for prescribed drugs among insurers, health care service contractors, and health maintenance organizations.

(c) Use of off-label indications often provides efficacious drugs at a lower cost.

(d) To prevent unfair methods of claims settlements, unfair competition, and unfair or deceptive acts or practices of insurers and prohibited acts or practices of health care service contractors or health maintenance organizations, this rule is adopted.

(2) Scope.

This regulation affects all insurance and health benefit policies and contracts providing coverage for drugs to a resident of this state which are issued, amended, delivered or renewed on or after January 1, 1995.

(3) Definitions. The following definitions are used in this section:

(a) "Drug" or "drugs" means any substance prescribed by a physician taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied to the skin to treat or prevent a disease, and specifically includes drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

(b) "Off-label" means the prescribed use of a drug which is other than that stated in its FDA approved labelling.

(c) "Peer-reviewed medical literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

(d) "Physician" means a medical doctor or other health care provider acting within the scope of his or her professional license.

(e) "Policy" or "contract" means any individual, group or blanket policy of insurance or health benefit contract issued by a disability insurer, health care service contractor, or health maintenance organization which is issued, amended, delivered or renewed on or after January 1, 1995, and which provides coverage for drugs to a resident of this state.

(f) "Standard reference compendia" means:

(i) The American Hospital Formulary Service-Drug Information;

(ii) The American Medical Association Drug Evaluation;

(iii) The United States Pharmacopoeia-Drug Information; or

(iv) Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

(4) Standards of coverage.

(a) No insurance policy or contract which provides coverage for prescription drugs to a resident of this state shall exclude coverage of any such drug for a particular indication on the grounds that the drug has not been ap-

proved by the Federal Food and Drug Administration for that indication, if such drug is recognized as effective for treatment of such indication:

- (i) In one of the standard reference compendia;
- (ii) In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
- (iii) By the Federal Secretary of Health and Human Services.

(b) Coverage of a prescription drug required by this section shall also include medically necessary services associated with the administration of the drug.

(c) This regulation shall not be construed to require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contra-indicated.

(d) This regulation shall not be construed to require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration.

[Statutory Authority: RCW 48.01.030, 48.02.060 and 48.30.010. 94-18-038 (Order R 94-17), § 284-30-450, filed 8/30/94, effective 9/30/94.]

TRADE PRACTICES

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

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

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

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

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

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

(7) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-550, filed 12/27/84.]

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

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

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

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

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

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

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

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

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

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

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-560, filed 12/27/84.]

WAC 284-30-570 Actual reason for canceling, denying or refusing to renew insurance to be disclosed. Whenever an insurer is required by law to give the reason for its canceling, denying, or refusing to renew insurance, as, for example, pursuant to RCW 48.18.291, 48.18.292, or

48.30.320, it shall give the true and actual reason for its action in clear and simple language, so that the insured or applicant will not need to resort to additional research to understand the real reason for the action. It is not sufficient, for example, to state that an insured "does not meet the company's underwriting standards." The reason why the individual does not meet such underwriting standards is what must be given. If the actual reason relates to medical information, the insurer may make a broad reference thereto and limit specific disclosure of details to the applicant's or insured's physician.

[Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-570, filed 12/27/84.]

WAC 284-30-572 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 284-30-580 Policies to be delivered, not held by agents. (1) RCW 48.18.260 requires that policies be delivered within a reasonable period of time after issuance. If an insurer relies upon its agents to make deliveries of its policies, the insurer, as well as the agent, is responsible for any delay resulting from the failure of the agent to act diligently.

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

(3) Agents may obtain policies from owners or insureds and hold such policies briefly for analysis or servicing, giving a receipt therefor in every instance, but shall promptly return any such policies to their owners or insureds. Agents shall not otherwise take custody of, or hold, insurance policies, whether for fee or at no charge, unless a family or

legal relationship clearly justifies such conduct, as, for example, where a policy belonging to a minor child of the agent is held, or where the agent is acting as a legal guardian or a court appointed representative and holds a policy of a ward or of an estate.

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

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

[Statutory Authority: RCW 48.02.060 (3)(a), 85-02-019 (Order R 84-8), § 284-30-580, filed 12/27/84.]

WAC 284-30-590 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 284-30-600 Unfair practices with respect to out-of-state group life and disability insurance. (1) Pursuant to RCW 48.30.010, except as provided in subsection (2) of this section it is an unfair method of competition and an unfair practice for any insurer to effect life or disability insurance coverage on individuals in this state under a group policy which is delivered to a policyholder outside this state when:

(a) Such policy or any certificate used therewith contains any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy.

(b) Such policy or any certificate used therewith has any title, heading, or other indication of its provisions which is misleading.

(c) Such coverage is being solicited by deceptive advertising.

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

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

(ii) Meet the requirements as to benefits and coverage mandated by chapter 48.21 RCW and rules effectuating that chapter, specifically including those set forth in chapter 284-51 WAC, and WAC 284-30-610 and 284-30-620;

(iii) With respect to long-term care insurance, also meet the requirements of chapter 48.84 RCW and chapter 284-54 WAC;

(iv) With respect to Medicare supplemental insurance, also meet the requirements of chapter 48.66 RCW and chapter 284-66 WAC; and

(v) Meet the loss ratio standards applicable to group insurance pursuant to RCW 48.66.100 and 48.70.030 and WAC 284-60-060.

(e) With respect to life insurance, the out-of-state group policy fails to comply with the provisions of RCW 48.24.100 through 48.24.260, WAC 284-23-550, 284-30-620, and 284-30-630.

(2)(a) Unless the individual insured pays all or substantially all of the cost of his or her coverage, subsection (1) of this section is not applicable to life or disability insurance coverage provided by any group policy issued for a group which would be qualified for group life insurance if the master policy were delivered to a policyholder in this state pursuant to RCW 48.24.035, 48.24.040, 48.24.050, or 48.24.095.

(b) Subsection (1) of this section is not applicable with respect to coverage under a master policy issued for an association group which would be qualified for group insurance under such policy if it were delivered to the policyholder in this state pursuant to the requirements of RCW 48.24.045:

(i) If such association clearly has a genuine purpose and existence of significant value to its members independent of its status as the group policyholder and independent of its involvement in insurance on behalf of its members, and if, further, there is a realistic and demonstrable basis related to the situs of the association or the residencies of a substantial portion of its members justifying the issuance of the group policy in the other state; or

(ii) If such association provides such coverage to each of its members, except those who may not qualify by reason of age, at no charge to them other than the standard membership dues or costs paid by each member.

(c) Subsection (1) of this section is not applicable with respect to a group policy issued for a group which qualifies for group insurance pursuant to RCW 48.24.060, 48.24.080, and 48.24.090.

(d) Except for coverages excluded by (a), (b), and (c) of this subsection, this section applies to all life and disability coverage on individuals in this state under group policies which are delivered to policyholders outside this state, specifically including those issued for trustee and other groups which are eligible for group insurance pursuant to RCW 48.21.010, 48.21.030, 48.24.020, 48.24.045, and 48.24.070.

(3) Except as provided in subsection (4)(c) of this section, for purposes of this section it is immaterial whether the insurance coverage is offered by means of a solicitation through a sponsoring organization, through the mail or other mass communication media, or through licensed agents or brokers.

(4) It is further defined to be an unfair practice for any insurer effecting group insurance coverage in this state through policies delivered to an out-of-state master policyholder to fail to do the following with respect to such insurance coverage:

(a) It must comply with the requirements of this state relating to advertising and claims settlement practices, and it must, upon request, furnish the commissioner copies of all advertising materials intended for use in this state;

(b) It must make available copies of any policy forms, and certificate forms used therewith, upon request of the commissioner; and

(c) Where the sale of such coverage to individuals in this state will be through solicitation by agents, solicitors or brokers, so that WAC 284-30-610 will be applicable to such solicitations, the insurer shall file with the commissioner copies of the pertinent group policy and certificate forms, and shall include a copy of the disclosure statement required by WAC 284-30-610, appropriately completed, which will be delivered to the Washington individuals who are solicited by the Washington licensees. Such material must be filed at least twenty days before the solicitation of coverage commences.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 91-03-073 (Order 90-14), § 284-30-600, filed 1/16/91, effective 4/1/91. Statutory Authority: RCW 48.02.060 (3)(a). 85-02-018 (Order R 84-7), § 284-30-600, filed 12/27/84.]

WAC 284-30-610 Unfair practices with respect to the solicitation of coverage under out-of-state group policies.

(1) It is an unfair method of competition and an unfair practice for an insurance company to permit its appointed licensed agent, and for an insurance agent, solicitor or broker, to solicit an individual in the state of Washington to buy or apply for disability insurance coverage when such coverage is provided pursuant to the terms of a group insurance policy delivered to an association or organization (or to a trustee designated by such association or organization), as policyholder, outside this state, if obtaining such coverage or continuing it is dependent upon the covered individual being a member of or in some way affiliated with such association or organization (other than as an employee, or a dependent of an employee, thereof), unless the following steps are taken:

(a) An accurately completed disclosure statement, substantially in the form set forth in subsection (2) of this section, must be signed by the soliciting licensee, and delivered to and brought to the attention of the individual being solicited before the application for coverage is completed and signed.

(b) The signed original disclosure statement must be left with such individual.

(c) A copy of the completed disclosure statement must be signed by such individual to acknowledge its receipt, and be submitted by the soliciting licensee, with the application for coverage, to the insurance company providing the coverage.

(d) The insurance company must confirm the accuracy of the form's contents, and retain such copy for not less than three years from the date the coverage commences.

(2) Disclosure statement form:

(Insurance Company's name and address)

IMPORTANT INFORMATION ABOUT THE INSURANCE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about the health insurance coverage offered to you under a group insurance policy issued by (insurance company), (to/on behalf of) (association or organization).

The policy is subject to and governed by the laws of the state of

The coverage (meets/does not meet) minimum insurance standards required of Washington state policies. You (will/will not) receive benefits required to be provided by Washington policies. The policy is designed to return benefits which are valued at a percentage (less than/equal to/greater than) the percentage of premiums that would be required under Washington state's rules or laws for group coverage.

The Washington State Insurance Commissioner will have limited authority to assist you concerning the coverage.

To keep this insurance coverage, you (must/need not) continue membership in the group. If you are not now a member, the initial cost of membership is \$. . . Additional dues or membership fees are currently \$. . . per . . . Membership costs (may/will not) increase in future years. You will also have the insurance premiums to pay.

The insurance coverage (can/can not) be discontinued by the group. It (can/can not) be terminated by the insurer. If the group organization ceases to exist, your coverage (would/would not) terminate. You (are/are not) entitled by the contract to convert your coverage to your own insurance policy.

(Group organization's name) and (insurance company's name) (are/are not) directly or indirectly subject to common control with respect to their management and policies, through ownership, by contract, or otherwise. (Group organization's name) (will/will not) be paid for its participation in this insurance program. (An explanation of payments may be inserted here.)

Apart from its involvement in insurance such as that offered to you, the organization engages in the following activities of value to its members: The organization has approximately . . . members, at this time. About . . . % of them do not participate in the group's health insurance program.

If you apply for this coverage, you (will/will not) have a "free look" (of . . . days*) during which you may cancel your contract and recover your premium without obligation. Your membership fee to join the group (is/is not) refundable. *(Omit phrase, "of . . . days", if there is no "free look.")

DELIVERED to the applicant this day of , 199. . . , by

(Signed) (agent, solicitor or broker).

Printed Name:

RECEIPT HEREOF IS ACKNOWLEDGED: Applicant.

(3) This section does not apply with respect to coverage provided to individuals under a group contract which is provided for a group of a type described in RCW 48.24.035, 48.24.040, 48.24.060, 48.24.070, 48.24.080, 48.24.090, or 48.24.095.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010. 91-03-073 (Order 90-14), § 284-30-610, filed 1/16/91, effective 4/1/91.]

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 284-30-700 Restrictions as to denial and termination of homeowners insurance affected by day-care operations. (1) Beginning August 1, 1985, pursuant to RCW 48.30.010, it shall be an unfair practice for any insurer transacting homeowners insurance to deny homeowners insurance to an applicant therefor, or to terminate any homeowners insurance policy covering a dwelling located in this state, whether by cancellation or nonrenewal, for the principal reason that an insured under such policy is engaged in the operation of a day-care facility, pursuant to chapter 74.15 RCW, at the insured location.

(2) This rule does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of business pursuits of an insured, specifically including those related to the operation of day-care facilities.

[Statutory Authority: RCW 48.02.060. 85-17-018 (Order R 85-3), § 284-30-700, filed 8/12/85.]

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 twenty-five 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.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.30.140, 48.30.150, 48.01.030 and 48.30.010(2). 90-20-104 (Order R 90-11), § 284-30-800, filed 10/2/90, effective 11/2/90. 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

284-32-010	Purpose.
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284-32-170	Appeal.
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284-32-200	Effective date.

WAC 284-32-010 Purpose. This plan of operation, hereinafter referred to as the plan, is adopted by the insurance commissioner, hereinafter called the commissioner, to assure the fair, reasonable, and equitable administration of the Washington Insurance Guaranty Association, pursuant to chapter 265, Laws of 1971 ex. sess., hereinafter referred to as the act.

[Emergency and Permanent Order R-71-3, § 284-32-010, filed 12/9/71.]

WAC 284-32-020 Board of directors. (1) The Washington Insurance Guaranty Association shall exercise its powers through a board of directors.

(a) The initial board of directors shall consist of six member insurers who have been appointed by the commissioner. The initial appointees, as designated by the commissioner, will serve staggered terms; two appointees shall serve until their successors are elected and qualified in 1973, two appointees shall serve until their successors are elected and qualified in 1974, and two appointees shall serve until their successors are elected and qualified in 1975.

(b) Succeeding members of the board of directors shall be elected by the member insurers. Such elections shall be conducted in conjunction with the annual meeting of the board of directors and votes shall be cast by the member insurers on a weighted basis using the net direct premium volume for the kinds of insurance specified in section 2 of the act as the determining factor in the number of votes allowed each member insurer. Each member insurer shall be given at least one vote in electing a member to the board of directors and shall be permitted to vote by proxy. All elected members shall serve for a term of three years and may be reelected for succeeding terms.

(c) The board of directors shall appoint from among their members a nominating committee. This committee shall select nominees to succeed board members whose terms are to expire at the annual meeting. The names of the nominees shall first be certified to the commissioner and if he does not disapprove within ten days they shall then be provided to the members at least two months prior to the annual meeting. The previously elected board members shall serve until their successors have been duly elected and qualified to serve.

(d) Vacancies on the board of directors shall be filled by appointment by the commissioner. Such appointees shall serve until the next annual meeting of the board of directors at which time an election will be held as provided in subsection (b) of this section. The term of office for such newly-elected director shall be the remaining term of the replaced director.

[Emergency and Permanent Order R-71-3, § 284-32-020, filed 12/9/71.]

WAC 284-32-030 Officers of board. The board of directors shall elect a chairman and such other officers as may seem desirable from among the representatives of its members, each to serve for a period of one year or until his successor is elected and qualified.

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[Emergency and Permanent Order R-71-3, § 284-32-030, filed 12/9/71.]

WAC 284-32-040 Quorum, votes required, proxies.

(1) A majority of the board shall constitute a quorum for the transaction of business and the acts of the majority of the board present at a meeting at which a quorum is present shall be the acts of the board: *Provided, however,* That an affirmative vote of five board members is required to:

- (a) Approve a contract with a servicing facility,
- (b) Levy an assessment or provide for a refund,
- (c) Borrow money.

(2) Each board member shall be entitled to one vote and shall be permitted to vote by proxy.

[Emergency and Permanent Order R-71-3, § 284-32-040, filed 12/9/71.]

WAC 284-32-050 Annual meetings. Beginning in 1973, member insurers and the board shall each hold an annual meeting at the office of the commissioner on the first Wednesday in February of each year, unless the board, upon proper notice, shall designate some other date or place.

[Emergency and Permanent Order R-71-3, § 284-32-050, filed 12/9/71.]

WAC 284-32-060 Board's annual meeting. At the board's annual meeting, the board shall:

(1) Review the plan and consider any amendments it may deem appropriate for adoption by a majority of the board members. Such amendments shall be effective upon written approval of the commissioner.

(2) Review each outstanding contract with servicing facilities and make any necessary corrections, improvements, or additions.

(3) Review operating expenses and covered claims' costs and determine if an assessment, or a refund of a prior assessment, would be appropriate and, if so, the amount thereof. The board shall levy any assessment or make any such refund in accordance with section 6 of the act. The board may waive collection from, or refuse refund to, a member insurer when the amount to be assessed or refunded is less than ten dollars.

(4) Review, consider and act on any other matters it may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-060, filed 12/9/71.]

WAC 284-32-070 Meeting after notice of insolvency. The board shall hold a meeting promptly after receiving notice from the commissioner of the insolvency of any member insurer. At such meeting or at any subsequent meeting the board shall consider and decide:

(1) Whether such insolvency meets the requirements of the act and is covered thereby.

(2) What method or methods shall be adopted to pay and discharge covered claims of the insolvent insurer. If the board decides to contract with a servicing facility, the board shall seek to secure the receiver's, liquidator's, or statutory successor's participation in such contract to assist the association in the performance of its legally-imposed duties. The association shall pursue all recoveries permitted to the insolvent insurer.

(3) What immediate action, if any, should be taken to assure the proper retention of the records of the insolvent

insurer necessary to the prompt, economical handling by the association of the covered claims. In this effort, the board or a designated servicing facility shall work with the receiver, liquidator, or statutory successor and seek his approval of having the board, or a designated servicing facility, take direct physical control of that portion of the insolvent insurer's records deemed by the board to be necessary for the discharge of its duties imposed by law.

(4) What persons should be hired by the association to implement and carry out the directives of the board made pursuant to its statutorily-imposed duties.

(5) To what extent and in what manner the board shall review and contest settlements, releases, judgments, orders, decisions, verdicts, and findings to which the insolvent insurer or its insured were parties in accordance with section 6(d) and 16 of the act.

(6) What assessment, if any, should be levied or whether any refund should be made to member insurers. If such assessment or refund is determined to be necessary, the board shall levy such assessments in accordance with sections 6(1)(c) through 6(2)(g) of the act. As provided in WAC 284-32-060(3), the board may waive assessments or refuse refunds of amounts less than ten dollars.

(7) What steps permitted by law are deemed necessary and shall take such action as necessary to protect the association's rights against the estate of the insolvent insurer.

(8) Any other matters it may deem appropriate for the proper administration of the association.

[Emergency and Permanent Order R-71-3, § 284-32-070, filed 12/9/71.]

WAC 284-32-080 Other meetings. The board may schedule such other regular meetings as it may deem appropriate. Special meetings of the board may be called by the chairman, and shall be called at the request of any two board members. Not less than five days' written notice shall be given to each board member of the time, place, and purpose or purposes of any special meeting. Any board member not present may consent in writing to any specific action taken by the board. Any action approved by a majority of the board's members at such special meeting at which a quorum is present, including those consenting in writing, shall be as valid a board action as though authorized at a regular meeting of the board. At such meeting the board may consider and decide any matter it may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-080, filed 12/9/71.]

WAC 284-32-090 Expenses of board members. Members of the board shall serve without compensation; but they may be reimbursed for necessary expenses incurred by them as members of the board of directors. Such expenses shall be submitted to the board for approval and subsequent payment.

[Emergency and Permanent Order R-71-3, § 284-32-090, filed 12/9/71.]

WAC 284-32-100 Official address of association. The official address of the association shall be the Office of the Insurance Commissioner, Insurance Building, Olympia, Washington 98504.

[Emergency and Permanent Order R-71-3, § 284-32-100, filed 12/9/71.]

(1995 Ed.)

WAC 284-32-110 Bank accounts, borrowing power.

The board may open one or more bank accounts for use in association business. Reasonable delegation of deposit and withdrawal authority to such accounts for association business may be made consistent with prudent fiscal policy. The board may borrow money from any person or organization, including a member insurer, or from an appointed servicing facility as the board may deem appropriate.

[Emergency and Permanent Order R-71-3, § 284-32-110, filed 12/9/71.]

WAC 284-32-120 Board may levy fee. The board may levy an equal annual fee not exceeding one hundred dollars per member insurer to cover the reasonable costs of administering the association. Such fee shall be credited against any assessment as provided for in section 6 of the act.

[Emergency and Permanent Order R-71-3, § 284-32-120, filed 12/9/71.]

WAC 284-32-130 Contract with servicing facility.

The board may contract with one or more persons, firms, or corporations to act as servicing facilities should the board receive notice from the commissioner of the insolvency of a member insurer. The designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer. Such contract terms may include:

(1) Terms of payment to the servicing facility;

(2) Extent of authority delegated to the servicing facility.

(3) Procedures for giving the receiver, liquidator, or statutory successor timely notice, sufficient to protect the association's right of subrogation against him, of each and every covered claim not otherwise reported to him.

(4) Procedures contemplated for the handling of covered claims as defined in section 3(4) of the act. These procedures shall include the right to request from, or offer to, any person arbitration of his covered claim.

(5) Procedures for the printing or preparation of forms necessary for the proper handling of covered claims.

(6) Requirements of bond for faithful performance.

(7) Any other provisions deemed appropriate by the board of directors.

[Emergency and Permanent Order R-71-3, § 284-32-130, filed 12/9/71.]

WAC 284-32-140 Claim settlements of one hundred fifty thousand dollars 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 fifty thousand dollars or more; except settlement of claims for first party property damage up to three hundred thousand dollars, which may be approved by any two members of the board.

[Statutory Authority: RCW 48.02.060 and 48.32.070. 93-19-001 (Order R 93-5), § 284-32-140, filed 9/1/93, effective 10/2/93. 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.]

WAC 284-32-150 Prevention of insolvencies. In order to effectuate the purposes set forth in section 11 of the act concerning the prevention of insolvencies, the board may develop procedures for discovering and reporting any

member that may be insolvent or in a financial condition hazardous to the policyholder's interests or the public interest. No such reports shall be considered public documents. The board of directors, at its annual meeting, or at any other meeting called for this purpose, may review the insurance code and regulations with a view towards making recommendations to the commissioner for the detection and prevention of insurer insolvency. The association may develop forms for reporting the history and cause of each insolvency processed and shall maintain a continuing file of such reports.

[Emergency and Permanent Order R-71-3, § 284-32-150, filed 12/9/71.]

WAC 284-32-160 Records, reports, audit. (1) A written record of the proceedings of each board meeting shall be made. The original of this record shall be retained by the chairman with copies being furnished to each board member, the commissioner, and, upon written request, any member insurer.

(2) The board shall make an annual report to the commissioner not later than March 30 of each year. Such report shall include a review of the association's activities and an accounting of its income and disbursements for the past year in a form approved by the commissioner.

(3) After the appointment of a receiver, liquidator, or statutory successor and the levy of an assessment by the association, the board shall, once every year, appoint certain of the member insurers to serve as an audit committee. The audit committee shall consist of three member insurers, at least two of which shall not have representatives on the board of directors. Such committee shall see to the proper auditing of all the books and records of the association and shall report its findings to the board and the commissioner.

[Emergency and Permanent Order R-71-3, § 284-32-160, filed 12/9/71.]

WAC 284-32-170 Appeal. Any member insurer aggrieved by an action of the association shall appeal, in writing, to the board before appealing to the commissioner. If such member insurer is aggrieved by the final action or decision of the board or if the board does not act on such complaint within thirty days, the member insurer may appeal to the commissioner, in writing, within thirty days after the action or decision of the board or the expiration of the thirty days.

[Emergency and Permanent Order R-71-3, § 284-32-170, filed 12/9/71.]

WAC 284-32-180 Indemnification. (1) Any person described in section 5 of the act shall be indemnified by the association against all expenses incurred in the defense of any action taken or not taken by him in the performance of his powers and duties under the Washington Insurance Guaranty Association Act, unless such person shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of his office. In the event of settlement before final adjudication, such indemnity shall be provided only if the association is advised by independent counsel that such person did not, in counsel's opinion, commit such a breach of duty.

(2) The expense of such indemnification shall be prorated and paid for by the member insurers in the proportion that the net direct written premiums of each member insurer for the calendar year proceeding commencement of such action, suit or proceeding bears to the net direct written premiums of all member insurers for the preceding calendar year.

(3) This indemnification is intended to operate as a supplement and additional safeguard to, and not in place of, the immunity granted by section 15 of the act.

[Emergency and Permanent Order R-71-3, § 284-32-180, filed 12/9/71.]

WAC 284-32-190 Conformity to statute. The Washington Insurance Guaranty Association Act as written, and as may be amended, is incorporated as part of this plan.

[Emergency and Permanent Order R-71-3, § 284-32-190, filed 12/9/71.]

WAC 284-32-200 Effective date. This regulation, WAC 284-32-010 through 284-32-200, shall be effective as an emergency regulation on December 10, 1971, and shall be effective as a permanent regulation on January 10, 1972.

[Emergency and Permanent Order R-71-3, § 284-32-200, filed 12/9/71.]

Chapter 284-34 WAC

CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

WAC

284-34-010	Credit life insurance.
284-34-020	Credit accident and health insurance.
284-34-030	Collection and remittance of premiums.
284-34-040	Rate filings and deviations from prima facie rates.
284-34-050	Refunds.
284-34-060	Effective date—Implementation.
284-34-070	Prohibited transactions.

WAC 284-34-010 Credit life insurance. (1) Except as hereafter qualified, the following rates for decreasing term life insurance may be considered as establishing "prima facie acceptable rates" for purposes of RCW 48.34.100(2). That is, rates which are filed by any company for the indicated coverage will be deemed to be acceptable without substantiating data if they do not exceed these premium rates.

(a) Single premium of \$.60 per coverage per \$100 of initial indebtedness repayable in twelve equal monthly installments during the period of coverage.

(b) Monthly premium of \$.96 per \$1000 of outstanding balances.

(2) Single premium rates for indebtedness repayable in installments other than twelve in number shall be one-twelfth of the above premium rate multiplied by the number of full months in the period of indebtedness. Premium rates for credit life insurance not covered under subsection (1) above shall be the actuarial equivalent of rates in subsection (1).

(3) The foregoing rates are presumed to produce reasonable benefits in relation to premiums only if:

(a) The credit life insurance contract contains no exclusion other than for suicide within two years of the effective date of the insurance, and

(b) Coverage is provided or offered to all debtors regardless of age; or to all debtors not older than the appli-

cable age limit, which shall not be less than attained age sixty-five if such limit applies to the age when the insurance attaches, or not less than attained age sixty-six years if such limit applies to the age on the scheduled maturity date of the debt.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-020 Credit accident and health insurance. (1) Except as hereafter qualified, the following rates for credit accident and health insurance may be considered as "prima facie acceptable rates" for purposes of RCW 48.34.100(2). That is, rates which are filed by any company for the indicated coverage will be deemed to be acceptable without substantiating data if they do not exceed these premium rates.

If premiums are paid in one sum for the entire duration of the indebtedness the following rates for \$100 of initial indebtedness repayable in indicated number of installments are applicable:

No. of Months Indebtedness is Repayable	Nonretroactive 14-day	Benefits 30-day	Retroactive 14-day	Benefits 30-day
6	\$ 1.00	\$.40	\$ 1.80	\$ 1.30
12	1.40	.80	2.20	1.70
24	2.20	1.60	3.00	2.50
36	3.00	2.40	3.80	3.30
48	3.50	2.90	4.30	3.80
60	3.90	3.30	4.70	4.20
72	4.20	3.60	5.00	4.50
84	4.40	3.80	5.20	4.70

(2) Premiums payable other than on a single premium basis, for indebtedness of monthly durations not shown above or for benefits on a basis different than illustrated above, shall be actuarially consistent with the above rates.

(3) The foregoing rates are presumed to produce reasonable benefits in relation to premiums only if:

(a) The coverage contains no exclusion for preexisting conditions except for those conditions which manifested themselves to the insured debtor by requiring medical diagnosis or treatment, or would have caused a reasonably prudent person to have sought the medical diagnosis or treatment, within six months preceding the taking of the application for insurance and which caused loss within the six months following effective date of coverage: *Provided, however,* That disability commencing thereafter resulting from such conditions shall be covered.

(b) Coverage is provided or offered to all debtors regardless of age or to all debtors not older than the applicable age limit, which shall not be less than attained age sixty-five if such limit applies to the age when the insurance attaches, or not less than attained age sixty-six years if such limit applies to the age on the scheduled maturity date of the debt.

(4) Any contract to which the foregoing rates apply may contain provisions excluding or restricting coverage in the event of pregnancy, intentionally and self-inflicted injury, foreign travel or residence, flight in nonscheduled aircraft, or war or military service. (Except in unusual cases such insurance should not be sold to military persons, since their pay continues through periods of disability.) If more restrict-

ed coverage is to be provided there must be an appropriate reduction in the foregoing premium standards.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-030 Collection and remittance of premiums. A creditor may remit and an insurer may collect premiums on either a single premium basis or on a monthly outstanding balance basis, unless the creditor adds identifiable insurance charges or premiums for credit insurance to the total amount of the indebtedness, and makes any direct or indirect finance, carrying, credit or service charges whatever to the debtor in connection with such insurance charge. Under such circumstances, the creditor has loaned the premium or insurance charge to the debtor and the premium on the insurance charge is deemed collected for the insurer as soon as it is added to the indebtedness, in which event the creditor must remit and the insurer must collect on a single premium basis only. A creditor may remit and an insurer may collect on the monthly balance basis if the insurance charge or premium is not added to the amount of the loan and does not constitute part of the outstanding indebtedness, or if no direct or indirect finance, carrying, credit or service charge is made to the debtor in connection with the insurance charge or premium.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-040 Rate filings and deviations from prima facie rates. (1) Any filing made pursuant to this regulation shall clearly indicate whether the insurer conceives that the rates in said filing fall within the acceptable rates published here or are higher than those published rates.

(2) Requests for higher rates than those established in this regulation for a debtor or a creditor or a class or classes of debtors or creditors will be approved on a showing made by the insurer satisfactory to the commissioner, that because of the nature of the risk, the mortality or morbidity experience which may reasonably be anticipated, will be significantly higher than the average anticipated experience, upon which the applicable rate standard was based. In passing upon such filing, the insurance commissioner will give consideration to available mortality and morbidity data pertaining to the debtors of a creditor or a class or classes of debtors of a creditor, previous experience, if any, for an actuarially credible period on such creditor's debtors, including the experience of any subsidiary or affiliate of the creditor, available age data, and a reasonable rate of expense. Age data and prior experience of the creditor's program should always be submitted.

(3) Commissions or other payments or allowances to creditors, agents or general agents shall never be considered a justification, or any part of a justification, of a higher rate as being reasonable in relation to benefits.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-050 Refunds. (1) RCW 48.34.110 requires that formulae for the refunding of unearned premiums be filed with and approved by the commissioner. To be approved, a refund formula must provide for a "sum of the digits" (also called the "Rule of 78") refund for single

premium straight line decreasing benefit plans, a prorata refund for level benefit plans, or an actuarially acceptable refund of the unearned premiums for other benefit plans. A formula need not provide for a refund or credit if the amount thereof is less than one dollar.

(2) Formulae filed with the commissioner before November 1, 1975, which are not in compliance with this rule are disapproved, and shall not be used with respect to policies or certificates issued or renewed after April 1, 1976.

[Order R-75-4, § 284-34-050, filed 9/25/75; Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-060 Effective date—Implementation.

This regulation shall become effective January 1, 1968. No form or rate approved before the date of this regulation issues shall be used in this state after January 1, 1968, except as hereinafter provided, unless it is resubmitted and reapproved by the commissioner.

All existing group credit insurance contracts on forms required to be filed with the commissioner shall be amended to conform to the requirements of this regulation, or be terminated, not later than the anniversary of the date of issue of the policy next following the effective date of this regulation.

[Order 324 (part), filed 9/26/67, effective 1/1/68.]

WAC 284-34-070 Prohibited transactions. (1) The following practices, when engaged in by insurers in connection, either directly or indirectly, with a credit life or credit disability insurance program, whether on a group or an individual basis, are hereby defined to be unfair methods of competition, and unfair and deceptive practices in the conduct of the business of insurance, pursuant to, and subject to the enforcement provisions of RCW 48.30.010:

(a) The offer or grant by an insurer or agent to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract.

(b) Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that such deposit shall offset or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(c) Deposit by an insurer, with a creditor bank or financial institution, of money or securities without interest or at less rate of interest than is currently being paid by the creditor bank or financial institution to other depositors of like amounts. This prohibition shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of business of the insurer.

(d) Any other practice which is followed by an insurer when such practice involves use of the financial resources of the insurer for the principal benefit of the credit institution.

(2) This rule shall become effective January 1, 1977, and the continuation or use of the practices defined in subsection (1) on and after said date is prohibited: *Provided,*

however, That any certificate of deposit outstanding on November 16, 1976, may be continued to its maturity date.

[Order R-76-5, § 284-34-070, filed 11/16/76.]

Chapter 284-36 WAC

DOMESTIC FRATERNAL MUTUAL PROPERTY INSURERS' AGENTS AND DIRECTORS

WAC

284-36-010	Application.
284-36-020	Agent-directors permitted.
284-36-030	Election or service as director prohibited.
284-36-040	Fiduciary responsibilities not affected.

WAC 284-36-010 Application. This regulation, WAC 284-36-010 through 284-36-040, shall apply only as to domestic fraternal mutual property insurers, as defined in RCW 48.36.410, and to any domestic stock insurer while it is a subsidiary of such a fraternal mutual property insurer.

[Order R 75-5, § 284-36-010, filed 10/22/75.]

WAC 284-36-020 Agent-directors permitted. Pursuant to the authority vested in the commissioner under RCW 48.07.130(3) up to one-third (to the nearest whole number) of the members of the board of directors of such an insurer may also be insurance agents of the insurer, and be entitled to receive, and receive from the insurer payment of, commissions or other compensation for insurance business written or serviced by them on the same bases as apply to other agents of the insurer in general. Agent-directors qualified under this provision are excepted from the prohibition contained in RCW 48.07.130(1), to the extent of their activities hereby authorized.

[Order R 75-5, § 284-36-020, filed 10/22/75.]

WAC 284-36-030 Election or service as director prohibited. No individual who is an insurance agent of such an insurer shall be elected or serve as a member of the insurer's board of directors if thereby the number of agent-directors of the insurer would exceed one-third (to the nearest whole number) of the total regular membership of the said board. Temporary vacancies on the board of directors resulting from death, disability or resignation of a director, shall not be deemed to reduce such total regular membership.

[Order R 75-5, § 284-36-030, filed 10/22/75.]

WAC 284-36-040 Fiduciary responsibilities not affected. Nothing in this regulations shall be deemed to affect the responsibilities of a director as a fiduciary of the insurer, its members or stockholders, or other legal responsibilities of a director.

[Order R 75-5, § 284-36-040, filed 10/22/75.]

Chapter 284-43 WAC
CERTIFIED HEALTH PLANS

WAC

284-43-040 Review and approval of certified health plan provider selection, termination, and dispute resolution provisions.

WAC 284-43-040 Review and approval of certified health plan provider selection, termination, and dispute resolution provisions. (1) Each certified health plan shall submit to the insurance commissioner all criteria used by the plan to select and terminate health care providers and provisions for the resolution of disputes with providers. If the criteria or provisions fail to meet the requirements of chapter 245-04 WAC, the commissioner may within thirty days of receipt reject the criteria or provisions, specifying in writing the manner in which they fail to meet the requirements. If the commissioner has not disapproved the criteria or provisions within thirty days, they are deemed approved. If at any time after the thirty-day period the commissioner finds that the criteria or provisions do not meet requirements, the commissioner shall, after a hearing, issue an order specifying the manner in which the criteria or provisions fail to meet the requirements, and stating when, within a reasonable period thereafter, the criteria or provisions shall be deemed no longer effective. The order shall not affect any selection or termination of providers or resolution of disputes made prior to expiration of the period set forth in the order.

(2) The commissioner will not require the public disclosure of proprietary or competitive selection and termination criteria. The certified health plan may designate parts of its provider selection and termination criteria as proprietary or competitive in nature. The plan must demonstrate that disclosure of the criteria would hurt the plan's ability to compete or to manage health services. Disclosure of criteria is proprietary or anticompetitive if revealing them would have the tendency to cause providers to alter their practice patterns in a manner that would harm efforts to contain health care costs. Disclosure of criteria is proprietary if revealing the criteria would cause the plan's competitors to obtain valuable business information.

If the commissioner rejects a plan's designation of certain criteria as proprietary or competitive, the plan may contest the commissioner's decision in accordance with chapter 34.05 RCW. The proceedings shall be conducted in a manner that prevents disclosure of the criteria that are the subject of the proceedings until and unless the commissioner's determination of criteria as not proprietary or competitive is sustained.

(3) The insurance commissioner will not act to arbitrate or mediate disputes between a provider and a certified health plan regarding the plan's decision not to include a provider or regarding any other dispute between a provider and a plan arising under, or by reason of, a provider contract or its termination.

[Statutory Authority: RCW 48.01.030, 48.02.060 (3)(a), 48.43.140, 43.72.100(4) and 43.72.100(6). 94-23-056, § 284-43-040, filed 11/14/94, effective 12/15/94.]

Chapter 284-44 WAC
HEALTH CARE SERVICES CONTRACTORS—
AGENTS—CONTRACT FORMATS—STANDARDS

WAC

284-44-010 Title and application.
284-44-030 Contract format required.
284-44-040 Contract standards required.
284-44-042 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined.
284-44-043 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.
284-44-045 Benefits for registered nurses' services.
284-44-046 Mammograms—Coverage requirements and exceptions.
284-44-050 Group certificates to be furnished.
284-44-070 Effective date.
284-44-100 Authority and purpose.
284-44-110 Applicability and scope.
284-44-120 Definitions.
284-44-130 When filing is required.
284-44-140 General contents of all filings.
284-44-150 Experience records.
284-44-160 Evaluating experience data.
284-44-170 Minimum required anticipated loss ratio.
284-44-190 Unique contract forms.
284-44-200 Effective date.
284-44-210 "Filing document" form—Standard contract filing information.
284-44-220 "Filing document" form—Nonstandard contract filing information.
284-44-240 Participating provider contracts.
284-44-250 Accounting method.
284-44-300 Purpose and applicability.
284-44-310 Agreement underwritten by insurance.
284-44-320 Agreement guaranteed by a surety company.
284-44-330 Agreement guaranteed by a deposit of cash or securities.
284-44-340 Modification of amount of reimbursement or indemnity.
284-44-345 Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required.
284-44-350 Records and reporting.
284-44-360 Effective date.
284-44-410 Form for reporting number of persons entitled to services.
284-44-450 PKU formula coverage requirements and exceptions.
284-44-500 Alternative care—General rules as to minimum standards.

DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

284-44-020 Agents, licensing or appointment required. [Order R-74-1, § 284-44-020, filed 6/4/74, effective 8/1/74.] Repealed by 84-08-001 (Order R 84-1), filed 3/22/84. Statutory Authority: RCW 48.44.050.
284-44-060 Minimum filing requirements. [Order R-74-1, § 284-44-060, filed 6/4/74, effective 8/1/74.] Repealed by 81-15-070 (Order R 81-3), filed 7/21/81, effective 10/1/81. Statutory Authority: RCW 48.44.050.
284-44-180 Contract forms excluded from minimum loss ratio requirements. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-180, filed 7/21/81, effective 10/1/81.] Repealed by 82-12-032 (Order R 82-3), filed 5/26/82. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1.

284-44-400 Assessments for examination costs. [Statutory Authority: RCW 48.44.050. 84-08-001 (Order R 84-1), § 284-44-400, filed 3/22/84.] Repealed by 91-07-053 (Order R 91-1), filed 3/19/91, effective 4/19/91. Statutory Authority: RCW 48.02.060.

WAC 284-44-010 Title and application. (1) This regulation, WAC 284-44-010 through 284-44-070, is promulgated pursuant to RCW 48.44.050 and 48.44.020, and may be cited as the "Washington state health care service contractor regulation."

(2) This regulation, chapter 284-44 WAC, shall apply to every health care service contractor (hereinafter referred to as "contractor") registered pursuant to RCW 48.44.015.

[Order R-74-1, § 284-44-010, filed 6/4/74, effective 8/1/74.]

WAC 284-44-030 Contract format required. Every health care service contract issued or renewed after December 31, 1974 shall conform to the following format standards:

(1) The style, arrangement and over-all appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers shall be plainly printed in type of a style in general use, the size of which shall be uniform and not less than eight-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point. The "text" shall include all printed matter except the name and address of the contractor, name or title of the policy, a brief description if any, and captions and subcaptions.

(2) The exceptions, reductions, and limitations (as those terms are defined in WAC 284-50-030) shall be set forth in the contract either included with the benefit provisions to which they apply, or under an appropriate caption such as "exclusions," "exceptions," or "exceptions and limitations," except that if an exception, reduction, or limitation specifically applies only to a particular benefit under the contract, a statement of such exception, reduction, or limitation shall be included with the benefit provision to which it applies.

(3) Each form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(4) It shall contain no provision purporting to make any portion of the contractor's charter, rules, constitution, articles of incorporation, or bylaws a part of the contract if the effect of such provision would be to incorporate into the contract exceptions, reductions, limitations or additional charges not otherwise set forth in the contract, unless such portion is set forth in full in the contract, or is attached thereto.

[Order R-74-1, § 284-44-030, filed 6/4/74, effective 8/1/74.]

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

(1) A contract shall not unreasonably limit benefits to a specified period of time. For example, a provision that services for a particular condition will be covered only for one year without regard to the amount of the benefits paid or provided, is not acceptable. Contracts may, however,

limit major medical benefits, supplemental accident benefits, and diagnostic x-ray and laboratory benefits to a reasonable period of time. Benefits may also be limited to a reasonable maximum dollar amount, and, in the case of doctor calls, to a reasonable number of calls over a stated period of time.

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

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

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

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

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

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

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

(9) No contract other than a conversion contract issued pursuant to chapter 284-52 WAC shall contain any provision having the effect of coordinating benefits with other health care service contracts, health maintenance agreements, or disability insurance policies, except that group contracts may provide for coordination of benefits pursuant to chapter 284-51 WAC, and except that any contract may provide for coordination with respect to governmental programs.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-44-040, filed 9/19/84; Order R-74-1, § 284-44-040, filed 6/4/74, effective 8/1/74.]

WAC 284-44-042 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined. (1)

Pursuant to RCW 48.44.460, each offer of new or renewal group coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Health care service contractors are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:

(a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical services shall be the same as are generally provided in the health care service contract for other injuries or musculoskeletal disorders. The coverage provisions may require:

- (i) That services either be rendered or referred by the covered individual's primary care physician; and
- (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
- (iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(b) Offers limited to only dental coverage shall provide coverage for dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for dental services shall be the same as are generally provided in the health care service contract for other injuries or dental conditions. The coverage provisions may require:

- (i) That services either be rendered or referred by the covered individual's primary care dentist; and
- (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
- (iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(c) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to the treatment of temporomandibular joint disorders in the

amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the health care service contract for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:

- (i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and
- (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
- (iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(2) Offers of the optional coverage required by subsection (1) of this section shall be included on the health care service contractor's application form(s) and retained by the health care service contractor for five years or until the completion of the next examination of the health care service contractor by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the health care service contractor shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.

(3) With respect to both medical and dental optional coverage of disorders of the temporomandibular joint, health care service contractors shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the health care service contractor to limit its coverage to its participating providers.

(4) For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:

(a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

(b) "Medical services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good medical practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(c) "Dental services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good dental practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(5) The requirements listed in the preceding subparagraphs of this section do not apply to those health care service contracts exempted by RCW 48.44.023 or 48.44.460(3), or other applicable law.

[Statutory Authority: RCW 48.44.460, 48.02.060 (3)(a) and 48.44.050. 92-24-043 (Order R 92-21), § 284-44-042, filed 11/25/92, effective 12/26/92.]

WAC 284-44-043 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every health care service contract which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the contract and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health care service contractor specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the contract and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the contract and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health care service contractor that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the contract and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health care service contractor must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health care service contractor may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health care service contractor in each contract and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. 92-21-099 (Order 92-15), § 284-44-043, filed 10/21/92, effective 11/21/92.]

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

"Benefits under this contract will not be denied for any health care service performed by a registered nurse licensed to practice under chapter 18.88 RCW, if first, the service performed was within the lawful scope of such nurse's license, and second, this contract would have provided benefits if such service had been performed by a doctor of medicine licensed to practice under chapter 18.71 RCW."

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

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

(4) To comply with RCW 48.44.290, no health care service contractor agreement may contain a provision which places restrictions or limitations on benefits for nurse-provided health care services which are not also placed on

benefits for doctor-provided health care services. An example of an impermissible provision would be one which limited the number of office calls made to a registered nurse to a number less than the limit for office calls made to a medical doctor. A contract provision which places such a limitation or restriction on benefits for nurse-provided health care services will be held to violate RCW 48.44.290, and will be the basis for disapproval of such agreement pursuant to RCW 48.44.020 (2)(f).

[Statutory Authority: RCW 48.44.050. 82-02-004 (Order R 81-8), § 284-44-045, filed 12/28/81.]

WAC 284-44-046 Mammograms—Coverage requirements and exceptions. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.44.325 by establishing definitions for the exceptions to coverage for mammograms. This regulation shall apply to every group and individual health care service contract which is delivered or issued for delivery or renewed in this state on or after September 1, 1992, that provides for hospital or medical care.

(2) For the purposes of RCW 48.44.325 and this regulation, supplemental contracts covering specified disease shall be defined to mean and include only those contracts which provide benefits to a member only in the event that the member contracts the disease or diseases specifically named in the contract. Also for the purposes of RCW 48.44.325 and this regulation, supplemental contracts covering limited benefits shall be defined to mean and include only those contracts providing only one of the following benefits: Hospital indemnity, accident only coverage, dental care, vision care, mental health care, chemical dependency care, pharmaceutical care, and podiatric care.

(3) Coverage of mammograms may be subject to standard contract provisions applicable to other diagnostic x-ray benefits such as deductible or copayment provisions.

(4) For purposes of RCW 48.44.325 and this regulation, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1992, upon which, at the health care service 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 mammogram coverage, with, if justified, an appropriate rate increase for any increased cost in providing mammogram coverage under the contract.

The failure of the health care service contractor to take any such steps does not prevent the contract from being "renewed." The intent of this section is to bring the mammogram coverage under the maximum number of contracts possible at the earliest possible time, by permitting the health care service contractor to exclude such coverage from only those contracts as to which there exists a right of renewal on the part of the contractholder without any change in any provision of the contract.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. 92-16-009 (Order R 92-4), § 284-44-046, filed 7/23/92, effective 8/23/92.]

WAC 284-44-050 Group certificates to be furnished. Every contractor shall issue to the employer, a

contract holder, or other person or association in whose name a contract is issued, for delivery to each person covered by a group contract, a certificate setting forth in summary form a statement of the essential features of the contract coverage, and to or for whom the benefits thereunder are payable. If family members are covered, only one certificate need be issued for each family. In the event that contracts are changed or amended, new certificates or a clearly understandable amendment to existing certificates shall be promptly furnished. The style, arrangement, and over-all appearance of the certificate shall not be less favorable than the requirements imposed by WAC 284-44-030. Such "certificate" may be in the form of a comprehensive booklet or brochure. The form of such certificate shall be filed with the insurance commissioner.

[Order R-74-1, § 284-44-050, filed 6/4/74, effective 8/1/74.]

WAC 284-44-070 Effective date. The effective date of this regulation shall be August 1, 1974.

[Order R-74-1, § 284-44-070, filed 6/4/74, effective 8/1/74.]

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

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

(2) Establish standards for the reasonableness of anticipated loss ratios to implement the authority of the commissioner to disapprove contract forms where the benefits provided are unreasonable in relation to the amount charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-100, filed 7/21/81, effective 10/1/81.]

WAC 284-44-110 Applicability and scope. This regulation applies to all health care service contractors registered in this state under chapter 48.44 RCW. It applies to every contract, rider and endorsement form and every rate schedule, and any modification or change thereof, which is required to be filed with the commissioner pursuant to RCW 48.44.040 and 48.44.020(2). It does not apply to health maintenance organizations registered in this state under chapter 48.46 RCW.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-110, filed 7/21/81, effective 10/1/81.]

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

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

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

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

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

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

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

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

(a) Claims processing costs

(b) Home office and field overhead

(c) Acquisition and selling costs

(d) Taxes

(e) Contribution to surplus

(f) All other costs except "claim" payments to or on behalf of the "subscriber."

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

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

(10) "Incurred claims" shall mean:

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

(b) the changes in reserves for "claims" which have been reported but not paid; plus

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

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

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

(13) "Subscriber" shall mean a person on whose behalf a "contract" or "certificate" is issued.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-120, filed 7/21/81, effective 10/1/81.]

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

(a) Before being offered for sale to the public,

(b) Before such forms are modified or rate schedules are changed, and

(c) Within thirty days after the end of a three-year period during which a previous filing has remained unchanged for such period, including filings made prior to the effective date of this regulation.

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

(3) If a return copy of the filing is desired it shall be submitted in duplicate. The duplicate copy will be stamped by the commissioner to indicate receipt of the filing and will be returned to the sender if a return self addressed envelope is enclosed with the filing.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-130, filed 7/21/81, effective 10/1/81.]

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

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

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

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

(4) Certification by an actuary, a corporate officer or other qualified designated individual that the filing is in compliance with the applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-140, filed 7/21/81, effective 10/1/81.]

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

- (a) Incurred claims,
- (b) Earned amounts charged,
- (c) Expenses, and
- (d) Contributions to the corporate reserve account.

(2) Such records shall include data for rider and endorsement forms which are used with the contract forms. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under contract forms which provide substantially similar coverage may be combined for recordkeeping purposes.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-150, filed 7/21/81, effective 10/1/81.]

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

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

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

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

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

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

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

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

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

(2) With the approval of the commissioner contract, rider and endorsement forms which provide substantially similar coverage may be combined for the purpose of determining the anticipated loss ratio.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-170, filed 7/21/81, effective 10/1/81.]

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

(1) Negotiated, experience rated or merit rated contract, rider or endorsement forms;

(2) Group contract forms designed to cover 25 or fewer subscribers or group contract forms which are designed to generate an unusually small amount charged per subscriber;

(3) Unusual employment, geographic, or other circumstances of the subscribers entailing high acquisition costs or other unusual expenses;

(4) A high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;

(5) Unusual product features such as long elimination periods, high deductibles and high maximum limits or

(6) Issuance on a basis where the benefits provided and amount charged are determined by an affiliated health care service contractor outside of this state as to which the health care service contractor does not have direct control of the services and benefits offered and the amount charged for such contract form.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-190, filed 7/21/81, effective 10/1/81.]

WAC 284-44-200 Effective date. This regulation, WAC 284-44-100 through 284-44-220, shall become effective on October 1, 1981.

[Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-200, filed 7/21/81, effective 10/1/81.]

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

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

STANDARD CONTRACT FILING INFORMATION

- (Health Care Contractor):
Contract Form Number
Effective Date Date Submitted
Individual Contract
Medicare Supplement Contract
Community Rated Contract
Conversion Contract
New Contract (attach contract)
No Change in Contract Past 3 years
If this is a Revision of an Existing Contract, check here (. . .) and attach appropriate endorsements/riders.
a) Experience Rate Change . . . %
b) Recoupment . . . %
c) Benefit Change(s) . . . %
d) Reserves . . . %

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

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

Table with 3 columns: Current Rate Period, First Prior Rate Period, Second Prior Rate Period

- Rate Period Experience From . . .to . . . From . . .to . . . From . . .to . . .
Earned Income
Paid Claims
Beginning Incurred Reserve
Ending Incurred Reserve
Incurred Claims

- Loss Ratio Percentage
Expenses
Gain/Loss
Contribution to Corporate Surplus

GENERAL INFORMATION:

- 1. . . .% of premium is charged for administering this contract.
2. a) . . .% is the overall annual trend factor used to project the new rates.
b) Annual trend factor by line of service:
Hospital . . .% Professionals. . .% Dental. . .% Other: . . .%
3. Rate Period Claim Breakdown:
Hospital % of total Profes- % of total Dental % of total Other % of total
\$. . . \$. . . \$. . . \$. . .
4. . . . months experience was used to develop the new rates.
From to
5. For what period are the new rates anticipated to remain in effect?
From to
6. The anticipated loss ratio over the period the new rates are assumed to remain adequate is%.
7. List the effective date and increase percentage of all rate changes in the past three rate periods.
1) (date) % 2) (date) % 3) (date) %
8. Comments or additional information
.
.
.
9. I hereby certify that this filing is in compliance with applicable laws and regulations of the state of Washington and that the benefits and services to be provided are reasonable in relation to the amount charged.

Signed

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

WAC 284-44-220 "Filing document" form—
Nonstandard contract filing information.

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

NONSTANDARD CONTRACT FILING INFORMATION

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

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

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

Table with 4 columns: Rate Period, Current Rate Period, First Prior Rate Period, Second Prior Rate Period. Rows include Experience, Earned Income, Paid Claims, Beginning Incurred Reserve, Ending Incurred Reserve, Incurred Claims, Loss Ratio Percentage, Expenses, Gain/Loss.

Experience
Refund or
Credit
Contribution
to Corporate
Surplus

Comments or additional information:

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

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

Signed

Title

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

WAC 284-44-240 Participating provider contracts.

(1) A "participating provider contract form" is that portion
of the participating provider contract described in subsection
(3) of this section or any variation approved by the commis-
sioner. Each participating provider contract form must be in
writing and filed with the commissioner for approval at least
fifteen days before use. Each filing shall include a transmit-
tal page as prescribed by the commissioner.

(2) Each participating provider contract must contain a
complete approved participating provider contract form
before it is used. "Use" of the participating provider contract
shall include, but not be limited to, execution by the health
care service contractor or the provider, effectuating the terms
of the contract, or referring enrolled participants to the
participating provider for nonemergent, in-area covered
services. When an approved participating provider contract
form is included verbatim in a participating provider con-
tract, the contract shall be deemed to be approved, and need
not be filed on an individual basis.

(3) Each participating provider contract form shall
consist of the following provisions or variations approved by
the commissioner:

(a) "{Name of Provider} hereby agrees that in no event,
including, but not limited to nonpayment by {Name of
HCSC}, {Name of HCSC}'s insolvency or breach of this
contract shall {Name of Provider} bill, charge, collect a
deposit from, seek compensation, remuneration or reimburse-
ment from, or have any recourse against an enrolled partici-
pant or person, other than {Name of HCSC}, acting on their
behalf, for services provided pursuant to this contract. This
provision shall not prohibit collection of {deductibles,
copayments, co-insurance, and/or noncovered services},
which have not otherwise been paid by a primary or second-
ary carrier in accordance with regulatory standards for
coordination of benefits, from enrolled participants in

accordance with the terms of the enrolled participant's subscriber agreement."

(b) "{Name of Provider} agrees, in the event of {Name of HCSC}'s insolvency, to continue to provide the services promised in this contract to enrolled participants of {Name of HCSC} for the duration of the period for which premiums on behalf of the enrolled participant were paid to {Name of HCSC} or until the enrolled participant's discharge from inpatient facilities, whichever time is greater."

(c) "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrolled participant's subscriber agreement."

(d) "{Name of Provider} may not bill the enrolled participant for covered services (except for deductibles, copayments or co-insurance) where {Name of HCSC} denies payments because the provider has failed to comply with the terms of the participating provider contract."

(e) "{Name of Provider} further agrees (i) that the above provisions (a), (b), (c), and (d) of this subsection {or identifying citations appropriate to the contract form} shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {Name of HCSC}'s enrolled participants, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {Name of Provider} and enrolled participants or persons acting on their behalf."

(f) "If {Name of Provider} contracts with other health care providers who agree to provide covered services to enrolled participants of {Name of HCSC} with the expectation of receiving payment directly or indirectly from {Name of HCSC}, such providers must agree to abide by the above provisions (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

(4) When an approved participating provider contract is modified, the modified contract need not be filed with the commissioner unless any provision contained in the approved participating provider contract form is modified, other than the name of the provider, in which case the modified contract form must be filed with the commissioner for approval at least fifteen days prior to use.

(5)(a) Every participating provider contract entered into after the effective date of this regulation shall be amended to comply with this regulation no later than April 1, 1992.

(b) Participating provider contracts entered into prior to the effective date of these regulations that followed previously approved participating provider contract forms shall be amended upon renewal to comply with the provisions of subsections (2) and (3) of this section, but in no event later than March 31, 1993.

[Statutory Authority: RCW 48.44.050, 48.44.070 and 48.02.060. 92-09-044 (Order R 92-2), § 284-44-240, filed 4/10/92, effective 5/11/92.]

WAC 284-44-250 Accounting method. Beginning January 1, 1983, to aid in the administration of chapter 48.44 RCW, every health care service contractor shall account for its business on the accrual basis, and any annual financial statement filed after December 31, 1983, pursuant to RCW 48.44.095, shall be reported on such accrual basis.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-250, filed 11/5/82, effective 1/1/83.]

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

(2) This regulation applies to every health care service contractor registered pursuant to chapter 48.44 RCW.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-300, filed 11/5/82, effective 1/1/83.]

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

(a) Have a continuous term;

(b) Fully insure the benefits of the persons who have paid for or contracted for covered health care services, which persons shall be designated as beneficiaries, when such services are not performed by the health care service contractor or a participant;

(c) Contain a provision that, in the event of cancellation, the coverage shall continue with respect to services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled without ninety days advance written notice to the insured or insurer by the cancelling party; and

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the insurer of any cancellation.

(2) The original or a true copy of the actual insurance contract or policy shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-310, filed 11/5/82, effective 1/1/83.]

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

(a) Be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340;

(b) Contain a provision that the bond will be for the benefit of the persons who have paid for or contracted for the health care services;

(c) Contain a provision that in the event of cancellation, the bond will continue to cover liabilities for services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled or terminated without ninety days advance written notice to the assured or surety company by the cancelling party;

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the surety company of any cancellation of such surety agreement.

(2) The original or a true copy of the actual surety bond shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-320, filed 11/5/82, effective 1/1/83.]

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

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

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value shall be the measurement.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-330, filed 11/5/82, effective 1/1/83.]

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

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

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

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

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

(2) The commissioner may from time to time require additional indemnification to be furnished when a review of the health care service contractor's affairs demonstrates that existing indemnification is inadequate.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-340, filed 11/5/82, effective 1/1/83.]

WAC 284-44-345 Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required. (1) Every health care service contractor shall annually, within one hundred twenty days of the closing date of its fiscal year, file with the commissioner a statement, prepared according to instructions published by the National Association of Insurance Commissioners (NAIC), verified by at least two of the principal officers of the health care service contractor showing its financial condition as of the closing date of its fiscal year. For purposes of WAC 284-44-345 only, fiscal year shall mean

that period from and including January 1 of each year, to and including December 31 of that same calendar year.

(2) The form of such annual statement shall be in the current form and content as promulgated by the National Association of Insurance Commissioners for hospital, medical, and dental service or indemnity corporations. Such forms shall be completed according to instructions published by the National Association of Insurance Commissioners and supplemented with additional information required by this chapter and by the commissioner. The statement, completed in black ink or typeface, shall be filed in duplicate, each of which shall be verified by the oaths and original signatures of at least two of the health care service contractor's principal officers, and notarized. The annual statement shall be accompanied by a monthly enrollment data Form IC-16-HC, and an additional data statement Form IC-13A-HC.

(3)(a) Every health care service contractor shall file quarterly reports of its financial condition with the commissioner. Except as specified herein, such reports shall be filed in the commissioner's office not later than the forty-fifth day after the end of each of the health care service contractor's calendar quarters. Such quarterly reports shall be prepared in the form and content as promulgated by the National Association of Insurance Commissioners for quarterly reporting by hospital, medical, and dental service or indemnity corporations, shall be prepared according to instructions published by the National Association of Insurance Commissioners and as supplemented for additional information required by this chapter and by the commissioner. The statement, completed in black ink or typeface, shall be filed in duplicate, each of which shall be verified by the oaths and original signatures of at least two of the health care service contractor's principal officers, and notarized.

(b) The first such quarterly report shall be due for the calendar quarter ending March 31, 1993.

(c) Quarterly reports for the fourth quarter of each year may be omitted, if and only if, the annual financial statement with a year ended as of the same date as the omitted fourth quarter report is filed with the commissioner on or before March 1, of the year immediately following the close of the fourth calendar quarter.

(4) The commissioner may require, as a part of any investigation by the commissioner, any health care service contractor to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the health care service contractor. Monthly financial reports shall be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. Such monthly financial reports shall be the internal financial statements of the company, accompanied by a schedule converting the financial statements to reflect financial position according to statutory accounting practices and submitted in a form using the same format and designations as quarterly financial reports of health care service contractors.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.44.050. 92-22-095 (Order R 92-20), § 284-44-345, filed 11/3/92, effective 12/4/92.]

WAC 284-44-350 Records and reporting. (1) Each health care service contractor shall maintain records which

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

(2) A health care service contractor using either a policy of insurance or a surety bond to provide for indemnification shall notify the insurance commissioner, health care services division, sixty days in advance of termination or cancellation of the contract or policy of insurance or surety bond.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-350, filed 11/5/82, effective 1/1/83.]

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

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

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

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

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:

For calendar year:

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

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

November

December

Date Signed

Title

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

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.]

WAC 284-44-500 Alternative care—General rules as to minimum standards. (1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group contract of a health care service contractor issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(4) A health care service contractor may require that home health agencies or similar alternative care providers

have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's contract.

(6) This section shall not apply to long-term care or Medicare supplement insurance contracts. This section shall not apply to guaranteed renewable contracts issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. 94-19-015 (Order R 94-16), § 284-44-500, filed 9/9/94, effective 10/10/94.]

Chapter 284-46 WAC

HEALTH MAINTENANCE ORGANIZATIONS

WAC

- 284-46-020 Form for reporting number of persons entitled to services.
- 284-46-060 Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required.
- 284-46-100 PKU formula coverage requirements.
- 284-46-500 Alternative care—General rules as to minimum standards.
- 284-46-506 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined.
- 284-46-507 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.
- 284-46-575 Participating provider contracts.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-46-010 Assessments for examination costs. [Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-010, filed 3/22/84.] Repealed by 91-07-053 (Order R 91-1), filed 3/19/91, effective 4/19/91. Statutory Authority: RCW 48.02.060.

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

REPORT OF NUMBER OF PERSONS ENTITLED TO HEALTH CARE SERVICES

Organization reporting:
For calendar year:

Pursuant to WAC 284-44-400(2), if a health care service contractor, or WAC 284-46-010(2), if a health maintenance organization, set forth below are the numbers of persons, including dependents, who were entitled to health care services during each month of the year indicated above,

excluding therefrom such persons who were not residents of this state:

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

Date Signed

Title

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

WAC 284-46-060 Requirement to file annual statement—Form of annual statement—Requirement to file quarterly statements—Authority to require filing of monthly financial statements—Compliance with NAIC instructions required. (1) Every health maintenance organization shall annually, within one hundred twenty days of the closing date of its fiscal year, file with the commissioner a statement, prepared according to instructions published by the National Association of Insurance Commissioners (NAIC), verified by at least two of the principal officers of the health maintenance organization showing its financial condition as of the closing date of its fiscal year. For the purposes of WAC 284-46-060 only, fiscal year shall mean that period from and including January 1 of each year, to and including December 31 of that same calendar year.

(2) The form of such annual statement shall be in the current form and content as promulgated by the National Association of Insurance Commissioners for health maintenance organizations. Such form shall be completed according to instructions published by the National Association of Insurance Commissioners and supplemented with additional information required by this chapter and by the commissioner. The statement, completed in black ink or typeface, shall be filed in duplicate, each of which shall be verified by the oaths and original signatures of at least two of the health maintenance organization's principal officers, and notarized. The annual statement shall be accompanied by a monthly enrollment data form IC-15-HMO, and an additional data statement form IC-14-HMO.

(3)(a) Every health maintenance organization shall file quarterly reports of its financial condition with the commissioner. Except as specified herein, such reports shall be filed in the commissioner's office not later than the forty-fifth day after the end of each of the health maintenance organization's calendar quarters. Such quarterly reports shall be prepared in the form and content as promulgated by the National Association of Insurance Commissioners for quarterly reporting by health maintenance organizations, shall be prepared according to instructions published by the National Association of Insurance Commissioners and shall be supplemented for additional information required by this chapter and by the commissioner. The statement, completed in black ink or typeface, shall be filed in duplicate, each of which shall be verified by the oaths and original signatures

of at least two of the health maintenance organization's principal officers, and notarized.

(b) The first such quarterly report shall be due for the calendar quarter ending March 31, 1993.

(c) Quarterly reports for the fourth quarter of each year may be omitted, if and only if, the annual financial statement with a year ended as of the same date as the omitted fourth quarter report is filed with the commissioner on or before March 1, of the year immediately following the close of the fourth calendar quarter.

(4) The commissioner may require, as a part of any investigation by the commissioner, any health maintenance organization to file monthly financial reports whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the health maintenance organization. Monthly financial reports shall be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial report is being filed. Such monthly financial reports shall be the internal financial statements of the company, accompanied by a schedule converting the financial statements to reflect financial position according to statutory accounting practices and submitted in a form using the same format and designations as quarterly financial reports of health maintenance organizations.

[Statutory Authority: RCW 48.02.060(3) and 48.46.200. 92-22-094 (Order R 92-19), § 284-46-060, filed 11/3/92, effective 12/4/92.]

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.]

WAC 284-46-500 Alternative care—General rules as to minimum standards. (1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual or group agreement of a health maintenance organization issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care by home health, hospice and home care agencies licensed under chapter 70.127 RCW at equal or lesser cost, or by employees of the health maintenance organization.

(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice, or home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services

shall be determined based on the medical needs of the individual insured patient.

(4) A health maintenance organization may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the agreement, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's agreement.

(6) This section shall not apply to long-term care or Medicare supplement insurance contracts. This section shall not apply to guaranteed renewable agreements issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. 94-19-015 (Order R 94-16), § 284-46-500, filed 9/9/94, effective 10/10/94.]

WAC 284-46-506 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined. (1) Pursuant to RCW 48.46.530, each offer of new or renewal group and individual coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Health maintenance organizations are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:

(a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical services shall be the same as are generally provided in the health maintenance agreement for other injuries or musculoskeletal disorders. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(b) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to

the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the health maintenance agreement for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:

- (i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and
- (ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and
- (iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint. This subsection applies only in those cases where the offeree has accepted any coverage.

(2) Offers of the optional coverage required by subsection (1) of this section shall be included on the health maintenance organization's application form(s) and retained by the health maintenance organization for five years or until the completion of the next examination of the health maintenance organization by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the health maintenance organization shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.

(3) With respect to coverage of disorders of the temporomandibular joint, health maintenance organizations shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the health maintenance organization to limit its coverage to its participating providers.

(4) For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:

(a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

(b) "Medical services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good medical practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(c) "Dental services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good dental practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(5) The requirements listed in the preceding subparagraphs of this section do not apply to those health maintenance agreements exempted by RCW 48.46.066 or 48.46.530(3), or other applicable law.

[Statutory Authority: RCW 48.46.530, 48.02.060 (3)(a) and 48.46.200. 92-24-044 (Order R 92-22), § 284-46-506, filed 11/25/92, effective 12/26/92.]

WAC 284-46-507 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1)

Every health maintenance agreement which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the agreement and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the health maintenance organization specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the agreement and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the agreement or any certificate of coverage thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued

scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every health maintenance organization that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the agreement and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every health maintenance organization must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The health maintenance organization may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the health maintenance organization in

each agreement and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitations.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.46.200. 92-21-098 (Order 92-14), § 284-46-507, filed 10/21/92, effective 11/21/92.]

WAC 284-46-575 Participating provider contracts.

(1) Except for the provision of emergency services, out-of-area services, or in exceptional circumstances approved in advance by the commissioner, if the health maintenance organization is unable to negotiate reasonable and cost effective participating provider contracts, a health maintenance organization must have written contracts with its participating providers.

(2) A "participating provider contract form" is that portion of the participating provider contract described in subsection (4) of this section or any variation approved by the commissioner. Each participating provider contract form must be in writing and filed with the commissioner for approval at least fifteen days before use. Each filing shall include a transmittal page as prescribed by the commissioner.

(3) Each participating provider contract must contain a complete approved participating provider contract form before it is used. "Use" of a participating provider contract shall include, but not be limited to, execution by the health maintenance organization or the provider, effectuating the terms of the contract, or referring enrolled participants to the provider for nonemergent, in-area covered services. When an approved participating provider contract form is included verbatim in a participating provider contract, the contract shall be deemed to be approved, and need not be filed on an individual basis.

(4) Each participating provider contract form shall consist of the following provisions or variations approved by the commissioner:

(a) "{Name of Provider} hereby agrees that in no event, including, but not limited to nonpayment by {Name of HMO}, {Name of HMO}'s insolvency or breach of this contract shall {Name of Provider} bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrolled participant or person, other than {Name of HMO}, acting on their behalf, for services provided pursuant to this contract. This provision shall not prohibit collection of {deductibles, copayments, co-insurance, and/or noncovered services}, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from enrolled participants in accordance with the terms of the enrolled participant's subscriber agreement."

(b) "{Name of Provider} agrees, in the event of {Name of HMO}'s insolvency, to continue to provide the services promised in this contract to enrolled participants of {Name of HMO} for the duration of the period for which premiums on behalf of the enrolled participant were paid to {Name of HMO} or until the enrolled participant's discharge from inpatient facilities, whichever time is greater."

(c) "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify

the rights and benefits contained in the enrolled participant's subscriber agreement."

(d) "{Name of Provider} may not bill the enrolled participant for covered services (except for deductibles, copayments or co-insurance) where {Name of HMO} denies payments because the provider has failed to comply with the terms of the participating provider contract."

(e) "{Name of Provider} further agrees (i) that the above provisions (a), (b), (c), and (d) of this subsection {or identifying citations appropriate to the contract form} shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {Name of HMO}'s enrolled participants, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {Name of Provider} and enrolled participants or persons acting on their behalf."

(f) "If {Name of Provider} contracts with other health care providers who agree to provide covered services to enrolled participants of {Name of HMO} with the expectation of receiving payment directly or indirectly from {Name of HMO}, such providers must agree to abide by the above provisions (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

(5) When an approved participating provider contract is modified, the modified contract need not be filed with the commissioner unless any provision contained in the approved participating provider contract form is modified, other than the name of the provider, in which case the modified contract form must be filed with the commissioner for approval at least fifteen days prior to use.

(6)(a) Every participating provider contract entered into after the effective date of this regulation shall be amended to comply with this regulation no later than April 1, 1992.

(b) Participating provider contracts entered into prior to the effective date of these regulations that followed previously approved participating provider contract forms shall be amended upon renewal to comply with the provisions of subsections (3) and (4) of this section, but in no event later than March 31, 1993.

[Statutory Authority: RCW 48.46.200, 48.46.243 and 48.02.060. 92-09-044A (Order R 92-3), § 284-46-575, filed 4/10/92, effective 5/11/92.]

Chapter 284-48 WAC

BULLETINS

WAC

284-48-010	License status of creditors under credit group policies—Commissions.
284-48-020	Authority of agents v. brokers: (1) Brokers of record, (2) marketing substandard auto, (3) rejected life and disability.

WAC 284-48-010 License status of creditors under credit group policies—Commissions.

To: All insurers writing credit life and credit accident and health insurance and all holders of group contracts of such insurance.

From: Lee I. Kueckelhan, Insurance Commissioner

Subject: (1) License status of creditors under credit group policies. (2) Commissions.

I

License status

An uneven practice has developed in this state with respect to the necessary license status of creditors who hold group master policies of credit life and credit accident and health insurance, insuring the lives and health of those persons buying personal property through credit transactions. Some insurers are insisting that such creditors be licensed for life and disability, and find themselves at a competitive disadvantage with other insurers who apparently are informing the creditors that such licensing is unnecessary.

RCW 48.17.060 provides as follows:

(1) No person shall in this state act as or hold himself out to be an agent, broker, solicitor, or adjuster unless then licensed therefor by this state.

(2) No agent, solicitor, or broker shall solicit or take applications for, procure, or place for others any kind of insurance for which he is not then licensed.

(3) This section shall not apply with respect to any person securing and forwarding information required for the purposes of group insurance covering the unpaid balance, or remaining payments proposed to be made, in connection with the purchase of merchandise or securities, and *where no commission or other compensation is payable on account of such insurance to such person.* (Emphasis supplied.)

(4) Any person violating this section shall be liable to a fine of not to exceed five hundred dollars and imprisonment for not to exceed six months for each instance of such violation.

It is clearly inherent in subsection (3) that licensing is necessary for such creditors if any "commission or other compensation" is payable to them on account of such insurance.

We are informed that certain insurers are attempting to avoid the licensing provision by referring to the compensation paid to the creditor as something other than commission. The term typically applied is "experience refund." The statute makes it clear that the use of the term "commission" is in no way of controlling importance in its application. It expressly says "commission *or other compensation.*" A true experience refund obviously cannot be promised, computed in amount or percentage, or paid, before the term of coverage to which it relates has expired and the experience has occurred and is known. Any compensation to the creditor on an agreed-upon amount or percentage is in no way an experience refund, and its being so labeled is a nullity without legal effect in the construction of the above statute.

This bulletin is notice to its recipients of the position of this office. Unlicensed creditors receiving compensation as described are put on notice that they must be licensed. Because this office does not in any way impute bad faith to creditors who find themselves in violation, we feel it appropriate to extend to them a reasonable period in which to qualify and become licensed. Therefore, it is our intention to wait until December 31, 1965, before invoking any sanctions with respect to such nonlicensing.

II

Commissions

A fundamental purpose of the model law of credit life and credit accident and health insurance (chapter 48.34 RCW) was the establishment of a reasonable relationship between the benefits under such insurance and the premium paid by the insured. This office, following the decision of the National Association of Insurance Commissioners, had adopted the fifty percent loss ratio as a benchmark in determining if such reasonable relationship exists.

It has now come to our attention that some insurers may be paying commissions, however denominated, on credit life and credit accident and health insurance that approach or even exceed fifty percent of premiums. Such commissions obviously cannot be contemplated in an over-all loss ratio of at least fifty percent, since administrative costs, taxes, and other expenses are obviously also involved. If at least fifty percent loss ratio were in fact contemplated, then the paying of commission approaching fifty percent would threaten solvency.

Therefore, you are advised that any rate of compensation to a licensed creditor which exceeds forty percent of premium on any basis or combination of bases will be considered by this office as prima facie evidence that the rate being charged is excessive.

This office will allow until June 30, 1965, for all master policies of group credit life and credit accident and health insurance then in force to comply with this section.

This office has no ready means of knowing the identities and locations of the various creditors holding master policies of group credit life and credit accident and health insurance in this state. Therefore, we are hereby asking all authorized insurers that write this form of insurance to bring the contents of this bulletin to the immediate attention of such creditors as may hold their contracts.

DATED at Olympia, Washington, this 23rd day of April, 1965.

.....
LEE I. KUECKELHAN
Insurance Commissioner

[Filed May 7, 1965.]

**WAC 284-48-020 Authority of agents v. brokers:
(1) Brokers of record, (2) marketing substandard auto,
(3) rejected life and disability.**

To: All licensed insurance producers.
From: Lee I. Kueckelhan, Insurance Commissioner
Re: Authority of agents v. brokers: (1) Brokers of Record, (2) Marketing substandard auto, (3) Rejected life and disability.

Misunderstandings seem to have developed as respects the statutory authority of certain producer licensees of this office. It is hoped that this bulletin can clear up some of the misunderstandings which, when acted upon, amount to violations of statutes. RCW 48.17.020 provides as follows:

"Broker" means any person who, on behalf of the insured, for compensation as an independent contractor, for commission, or fee, and not being an agent of the insurer, solicits, negotiates, or procures insurance or reinsurance or the renewal or continuance thereof, or in any manner aids therein, for insureds or prospective insureds other than himself.

RCW 48.17.060 provides, among other things, that no one can act as or hold himself out to be a broker unless licensed as such. Violation carries a maximum fine of five hundred dollars and maximum imprisonment for six months. In addition, a person violating these statutes would put his existing licenses, if any, in immediate jeopardy under the provisions of RCW 48.17.530.

It is possible to violate the above statutes in many ways. By way of illustration, and not limitation, we set out three particular factual patterns that have come to our attention where there has been apparent noncompliance:

1. BROKERS OF RECORD

We have learned of persons licensed only as agents receiving appointments as "brokers of record" for buyers of insurance, and even making up specifications and calling for bids on behalf of their "principals" — the prospective insureds. This has come about, apparently, by a misapplication or misinterpretation of our statute relating to sharing commissions (RCW 48.17.490). That statute merely forbids the sharing of commissions with persons not licensed for the same class of business; it does not and cannot have the effect of automatically making an agent into a broker, and thus render all statutes based on the distinction nugatory.

Only licensed brokers can undertake to represent insureds in seeking insurers for particular lines of insurance in this state. Any document executed by an insured that purports to appoint someone other than a licensed broker as a broker of record on behalf of such insured must be considered void and of no effect. (It is to be noted that referring to such a person as an "agent of record" or "producer of record" or other title cures nothing. The only operative fact is the role played by that person in the insurance transaction. If he purports to act as a representative of the insured in negotiation of insurance with any insurer which has not appointed him he is acting as a broker, and must be licensed as such.)

2. SUBSTANDARD AUTOMOBILE MARKETING

Certain carriers do business in this state by appointing only one agent or general agent (referred to hereafter as the "official agent"), which official agent thereafter accepts applications and premiums sent to him by any number of other agents (referred to hereafter as "unofficial agents") around the state who might need a substandard market. Such unofficial agents have no appointment from the insurer involved, yet they usually (1) have in their offices the rate books, literature, and forms of such insurer, (2) are authorized to quote rates to prospective insureds, and (3) are authorized to collect and forward the premiums of the prospective insureds. The public has every reason to believe that a person with such indicia of authority to act on an insurer's behalf has actual authority to do so. The occasion

for harm in such an arrangement is obvious and real. We have had instances in which the unofficial agent has defalcated with premium money, and both the official agent and the company have attempted to turn their backs to the matter as if it didn't concern them. This is not in the public interest.

Again, here, the only plausible statutory support for the marketing arrangement appears to be in RCW 48.17.490, relating to the sharing of commissions. That section in no way authorizes the described method of doing business.

The only class of licensee with authority to take applications for such insurance and to collect premiums therefor, without being appointed by the insurer, is the broker. The broker's bond is, indeed, designed to give the protection otherwise lacking. The most any nonappointed agent can do in such a transaction is to refer such prospective insured either to an appointed agent or to a broker, and then share the commission with that appointed agent or broker if the appointed agent or broker wishes to enter into such a commission-sharing arrangement. The nonappointed agent cannot take an operative part in the insurance transaction, cannot solicit the insurance, cannot quote rates, cannot take applications, cannot collect premiums, cannot in any way give the public reason to believe he has authority to represent the company for which he is not appointed.

Because this particular disfavored arrangement is apparently widespread, and has not heretofore been challenged, we feel it is appropriate to allow a reasonable period of time during which corrective action can be taken by licensees and companies that find themselves in violation. Such corrective action may, in some cases, take the form of agents becoming licensed as brokers. In other cases the insurers may decide to make such de facto agents their appointed agents. Perhaps other companies may simply operate on a referral basis as described above. In any event, it would appear that June 30, 1966, would allow ample time to accomplish whatever changes are required. Cases of violation coming to our attention subsequent to that date will result in appropriate disciplinary action against both the producer and company in violation.

3. REJECTED LIFE AND DISABILITY BUSINESS

A life and disability agent must be separately licensed as to each insurer which he holds himself out to be authorized to represent. Only where each company for which such agent is licensed has (1) rejected a particular risk, and (2) has consented to its placement elsewhere, can such agent place such business with another authorized insurer as to which he is not licensed. This is the clear meaning of RCW 48.17.230, which provides as follows:

A licensed agent appointed by an insurer as to life or disability insurances, may, if with the knowledge and consent of such insurer, place any portion of a life or disability risk which has been rejected by such insurer, with other authorized insurers without being licensed as to such other insurers.

Violation of this statute is grounds for disciplinary action against the agent involved. If the life or disability agent desires to place nonrejected business with companies

with which he is not licensed, he too must be licensed as a broker.

(A life or disability risk may be considered "rejected", however, if the insurer refuses to write it at standard rates. The legal effect of the insurer's willingness to write the coverage at an increased rate is a counteroffer, not acceptance of the applicant's previous offer.)

- Note: 1. Nothing in the foregoing bulletin is intended to be construed as prohibiting practices permitted or required by operation of (a) the Washington Automobile Assigned Risk Plan, or (b) RCW 48.15.080, which relates to the placement of surplus lines.
- 2. Applications for broker's licenses may be obtained at our Olympia, Seattle, and Spokane offices.

LEE I. KUECKELHAN
Insurance Commissioner

DATED at Olympia, Washington, May 6, 1966.

[Filed May 18, 1966.]

Chapter 284-49 WAC
WASHINGTON BASIC COVERAGE POLICY
(SMALL GROUP) INSURANCE REGULATION

WAC

- 284-49-010 Scope.
- 284-49-020 Supplanting or superseding of existing policies.
- 284-49-050 Definitions.
- 284-49-100 Forms—prior approval.
- 284-49-115 General contents of form and rate filings.
- 284-49-300 Minimum policy requirements.
- 284-49-330 Minimum coverage.
- 284-49-500 Standards for loss ratios.
- 284-49-510 Filing requirements.
- 284-49-520 Experience records.
- 284-49-900 Collection of data and reporting.
- 284-49-999 Separability.

WAC 284-49-010 Scope. The regulations contained in this chapter shall apply to all policies or contracts issued to groups of fewer than twenty-five employees by disability insurers, health care service contractors and health maintenance organizations, pursuant to the authority of chapter 187, Laws of 1990, and such policies or contracts shall be referred to as "basic coverage policies." All other policies or contracts issued by disability insurers, health care service contractors, and health maintenance organizations shall conform to all other provisions of the Insurance Code and regulations issued thereunder applying to the type of policy or contract being issued.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-010, filed 9/4/90, effective 10/5/90.]

WAC 284-49-020 Supplanting or superseding of existing policies. Carriers shall not issue a basic coverage policy under the authority of chapter 187, Laws of 1990, to replace group coverage subject to mandated benefits existing on June 7, 1990, until the next anniversary date of the issuance of the group coverage agreement, unless such coverage is terminated for reasons unrelated to availability of a basic coverage policy regulated by this chapter. If two

or more plans are offered by the group at June 7, 1990, the renewal or anniversary date for the group policy covering the largest number of employees in the group, shall determine the next anniversary date of the group coverage agreement.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-020, filed 9/4/90, effective 10/5/90.]

WAC 284-49-050 Definitions. Unless otherwise specifically excepted, the definitions contained in this regulation shall apply throughout this chapter and to all policies within the scope of this chapter.

(1) "Carrier" is a disability insurer, health care service contractor or health maintenance organization authorized to do business in this state which has chosen to issue coverages within the scope of chapter 187, Laws of 1990, and this chapter.

(2) "Policy," "contract," and "agreement" shall be interchangeable and shall be the contractual document between a carrier and a group which creates a liability of the carrier for the provision of or indemnity for health care services within the scope of this chapter.

(3) "Group" shall mean a group composed of eligible employees of a single employer, and their dependents. Such employees shall be not more numerous than twenty-four in number. Employees shall include all persons, including an owner or partner, scheduled to work for the employer twenty or more hours per week and for at least twenty-six weeks per year. For the purposes of determining an employer's eligibility for a basic coverage policy under the authority of chapter 187, Laws of 1990, and this chapter, employees may not be segregated by division, job responsibilities, employment status, employment location, or any other rationale. For purposes of this chapter, group size will be determined at the time of application for a basic coverage policy, and on each anniversary of the date of issue of the basic coverage policy. Carriers shall confirm the size of groups by certification of the employer, which certification shall be maintained in the carrier's files.

(4) "Basic coverage" as authorized by chapter 187, Laws of 1990, and this chapter, means basic services rendered by health professionals licensed pursuant to chapters 18.57 and 18.71 RCW, together with hospital expenses.

(5) "Subscriber" shall mean an enrolled eligible employee with coverage under a basic coverage policy.

(6) "Eligible dependent" shall mean an enrolled dependent of a subscriber entitled to coverage under a basic coverage policy or certificate.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-050, filed 9/4/90, effective 10/5/90.]

WAC 284-49-100 Forms—prior approval. No contract, endorsement, amendment, rider, certificate or other form used in connection with policies within the scope of this chapter shall be issued, delivered or used, by any carrier, unless it has been filed with the commissioner by the carrier and approved by the commissioner prior to any use of such forms in this state.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-100, filed 9/4/90, effective 10/5/90.]

WAC 284-49-115 General contents of form and rate filings. Each form filing submitted to the commissioner for approval shall contain a transmittal page as prescribed by the commissioner and the following materials arranged in this order:

- (1) The printed form or forms, completed in John Doe fashion;
- (2) Rates, manuals of classification, manuals of rules and premiums, and modifications thereof;
- (3) Actuarial memorandum, which contains, at a minimum, the information set forth in WAC 284-49-510; and
- (4) Any additional required enclosure.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-115, filed 9/4/90, effective 10/5/90.]

WAC 284-49-300 Minimum policy requirements. Except as specifically exempted or modified by chapter 187, Laws of 1990, or this chapter, basic coverage policies shall comply in all respects with chapters 48.21, 48.44 and 48.46 RCW, other applicable provisions of the Insurance Code, and all applicable regulations issued thereunder.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-300, filed 9/4/90, effective 10/5/90.]

WAC 284-49-330 Minimum coverage. Every basic coverage policy issued pursuant to chapter 187, Laws of 1990, and this chapter will, as a minimum, provide at least "basic coverage." Every such policy may provide additional benefits, at the discretion of the carrier, but associated forms are subject to approval prior to use in accordance with WAC 284-49-100.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-330, filed 9/4/90, effective 10/5/90.]

WAC 284-49-500 Standards for loss ratios. (1) Basic coverage policies issued by authority of chapter 187, Laws of 1990, shall return a cumulative loss ratio of at least seventy percent. Such loss ratio shall be on the basis of incurred claims and earned premiums for all calculating or rating periods such that the cumulative loss ratio from inception equals or exceeds the seventy percent minimum loss ratio. Where coverage is provided on a direct service rather than indemnity basis, such loss ratio shall be on the basis of incurred health care expenses and earned premiums for such period. For purposes of achieving and maintaining the minimum cumulative loss ratio, the experience of all basic coverage policies of a carrier shall be combined.

(2) All claim experience for basic coverage policies shall be pooled for the purposes of establishing premiums and rates; i.e., the claim experience of a given individual group shall not be a factor in determining its rates.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-500, filed 9/4/90, effective 10/5/90.]

WAC 284-49-510 Filing requirements. All basic coverage policy forms, riders, and rates filed for initial use on or after June 7, 1990, and any future rate adjustment thereto, shall demonstrate compliance with the loss ratio requirements of WAC 284-49-500. All filings of forms shall be accompanied by the proposed schedule of rates and an actuarial memorandum completed and signed by a qualified actuary as defined in WAC 284-05-060.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-510, filed 9/4/90, effective 10/5/90.]

WAC 284-49-520 Experience records. Carriers shall maintain records of earned premiums and incurred claims, for each basic coverage policy, rider, endorsement and similar forms.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-520, filed 9/4/90, effective 10/5/90.]

WAC 284-49-900 Collection of data and reporting.

(1) Each carrier of basic coverage policies shall collect and maintain the following data, by county, in relation to the basic coverage policies it issues. Such data will be kept for each basic coverage policy and every variant of such policy.

(a) Number of groups purchasing policy (include as a separate policy each and every variant of the basic coverage policy).

(b) For each employer purchasing a basic coverage policy, the number of employees electing not to be covered under the group policy.

(c) Number of employees covered under each basic coverage policy.

(d) Number of dependents covered under each basic coverage policy.

(e) Initial premium for the basic coverage policy.

(f) Each requested premium increase or decrease by date of request, amount of increase or decrease, and date of the commissioner's approval.

(g) For each variant of the basic coverage policy, a description of the endorsements or variations from the basic coverage policy.

(h) Number of groups, employees, and employee dependents covered under a basic coverage policy who previously had no insurance coverage.

(i) Number of groups, employees, and employee dependents covered under a basic coverage policy who previously had insurance coverage.

(j) Total premium charged and collected on basic coverage policies, by month.

(k) Total claims reported and paid, by month.

(2) Each carrier shall on or before the first day of February and August of each year, beginning on February 1, 1991, report to the commissioner, in summary form, the information collected pursuant to subsection (1) of this section for the six month period immediately preceding the reporting date. Reports filed in February of each year shall cover the preceding July through December. Reports filed in August of each year shall cover the preceding January through June. Each carrier shall maintain the detail used to support such summary reports until the completion of the

next financial and market conduct examination of the carrier by the commissioner's staff.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-900, filed 9/4/90, effective 10/5/90.]

WAC 284-49-999 Separability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

[Statutory Authority: RCW 48.02.060 [(3)](a), 48.18.110(2), 48.44.020 (2)(d), 48.44.050, 48.46.060 (3)(d), 48.46.200 and 1990 c 187. 90-18-076 (Order 90-10), § 284-49-999, filed 9/4/90, effective 10/5/90.]

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

ADVERTISING

- 284-50-010 Title and purpose.
- 284-50-020 Applicability.
- 284-50-030 Definitions.
- 284-50-040 Method of disclosure of required information.
- 284-50-050 Form and content of advertisements.
- 284-50-060 Deceptive words, phrases, or illustrations prohibited.
- 284-50-070 Exceptions, reductions, and limitations to be disclosed.
- 284-50-080 Preexisting conditions.
- 284-50-090 Disclosure of provisions relating to renewability, cancellability, and termination.
- 284-50-100 Testimonials or endorsements by third parties.
- 284-50-110 Use of statistics.
- 284-50-120 Identification of plan or number of policies.
- 284-50-130 Disparaging comparisons and statements.
- 284-50-140 Jurisdictional licensing and status of insurer.
- 284-50-150 Identity of insurer.
- 284-50-160 Group or quasi-group implications.
- 284-50-170 Introductory, initial, or special offers.
- 284-50-180 Reduced initial premium rates.
- 284-50-190 Statements about an insurer.
- 284-50-200 Advertising file to be maintained.
- 284-50-210 Violation defined as unfair practice.
- 284-50-220 Severability provision.
- 284-50-230 Effective date.

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284-50-400	Hospital confinement indemnity coverage, outline of coverage.
284-50-405	Major medical expense coverage, outline of coverage.
284-50-410	Disability income protection coverage, outline of coverage.
284-50-415	Accident only coverage, outline of coverage.
284-50-420	Specified disease or specified accident coverage, outline of coverage.
284-50-425	Limited benefit health coverage, outline of coverage.
284-50-430	Requirements for replacement.
284-50-435	Separability.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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

ADVERTISING

WAC 284-50-010 Title and purpose. (1) This regulation, WAC 284-50-010 through 284-50-230, shall be known and may be cited as the "Washington disability insurance advertising regulation."

(2) The purpose of this regulation is to assure truthful and adequate disclosure of all material and relevant information in the advertising of disability insurance (as defined in RCW 48.11.030), health care service contractors' agreements (as defined in RCW 48.44.020), and health maintenance agreements (as defined in RCW 48.46.020). This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of disability insurance and health care agreements in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy or agreement of such insurance offered through various advertising media. RCW 48.30.040, 48.44.110 and

48.46.130 prohibit false, deceptive or misleading advertising in the conduct of the business of insurance and in the conduct of the business of a health care service contractor and a health maintenance organization. Because those statutes establish only general standards, this regulation establishes specific standards for advertisements relating to individual, group, blanket, and franchise disability, insurance and individual and group health care service contractors' agreements and health maintenance agreements.

[Order R-76-2, § 284-50-010, filed 3/4/76; Order R-73-1, § 284-50-010, filed 2/28/73, effective 4/1/73.]

WAC 284-50-020 Applicability. (1) These rules shall apply to every "advertisement," as that term is hereinafter defined, in WAC 284-50-030, subsections (1), (7), (8) and (9), unless otherwise specified in these rules, intended for presentation distribution, or dissemination in this state when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, or solicitor as those terms are defined in the insurance code of this state and these rules.

(2) Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the insurer for whom such advertisements are prepared.

[Order R-76-2, § 284-50-020, filed 3/4/76; Order R-73-1, § 284-50-020, filed 2/28/73, effective 4/1/73.]

WAC 284-50-030 Definitions. (1) An advertisement for the purpose of these rules shall include:

(a) Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards, and similar displays; and

(b) Descriptive literature and sales aids of all kinds issued by an insurer, agent, or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

(c) Prepared sales talks, presentations, and material for use by agents, brokers, and solicitors.

(2) "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides disability benefits, or medical, surgical, or hospital expense benefits, whether on an indemnity, reimbursement, service, or prepaid basis, except when issued in connection with another kind of insurance other than life and except disability, waiver of premium, and double indemnity benefits included in life insurance and annuity contracts.

(3) "Insurer" for the purposes of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health care service contractor, health maintenance organization, and any other legal entity which is defined as an "insurer" in the insurance code of this state and is engaged in the advertisement of a policy as "policy" is defined in this regulation.

(4) "Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

(5) "Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

(6) "Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

(7) "Institutional advertisement" for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance, or the promotion of the insurer.

(8) "Invitation to inquire" for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about the product and which is limited to a brief description of the loss for which the benefit is payable, and which may contain:

(a) The dollar amount of benefit payable, and/or

(b) The period of time during which the benefit is payable; provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

(9) "Invitation to contract" for the purpose of these rules shall mean an advertisement which is neither an invitation to inquire nor an institutional advertisement.

[Order R-76-2, § 284-50-030, filed 3/4/76; Order R-73-1, § 284-50-030, filed 2/28/73, effective 4/1/73.]

WAC 284-50-040 Method of disclosure of required information. All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statement to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

[Order R-73-1, § 284-50-040, filed 2/28/73, effective 4/1/73.]

WAC 284-50-050 Form and content of advertisements. (1) The format and content of an advertisement to which these rules apply shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the insurance commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

(2) Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

[Order R-73-1, § 284-50-050, filed 2/28/73, effective 4/1/73.]

WAC 284-50-060 Deceptive words, phrases, or illustrations prohibited. (1) No advertisement shall omit information or use words, phrases, statements, references, or illustrations if the omission of such information or use of such words, phrases, statements, references, or illustrations has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

(2) No advertisement shall contain or use words or phrases such as, "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help pay your hospital and surgical bills"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

(3) An advertisement shall not contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as, describing a waiting period as a "benefit builder," or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions, and reductions shall fairly and accurately describe the negative features of such limitations, exceptions, and reductions of the policy offered.

(4) No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "extra cash"; "extra income"; "extra pay"; or substantially similar words or phrases because such words and phrases have the capacity, tendency, or effect of misleading the public into believing that the policy advertised will, in some way, enable them to make a profit from being hospitalized.

(5) No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

(6) No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

(7) An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobile accidents, shall clearly

and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY"; "THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY."

(8) An advertisement of a direct response insurance product shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan," or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

(9) The phrase "tax free" shall not be used in or as a heading, caption, or title in any advertisement and shall not be unduly or deceptively emphasized, but it may be used in connection with a reasonably complete explanation of the Internal Revenue Service rules applicable to the particular benefits afforded by the policy or policies advertised.

[Order R-73-1, § 284-50-060, filed 2/28/73, effective 4/1/73.]

WAC 284-50-070 Exceptions, reductions, and limitations to be disclosed. (1) When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

(2) When a policy contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding subsection (1) shall disclose the existence of such periods.

(3) An advertisement shall not use the words "only"; "just"; "merely"; "minimum"; or similar words or phrases to deceptively describe or unfairly minimize the applicability of any exceptions and reductions contained in the policy advertised.

(4) When a policy contains a provision permitted by RCW 48.20.192, 48.20.202, or 48.20.212 (Optional standard provisions No. 15, 16, and 17), an advertisement which is subject to the requirements of WAC 284-50-070(1) shall disclose clearly the effect of such provisions.

[Order R-76-2, § 284-50-070, filed 3/4/76; Order R-73-1, § 284-50-070, filed 2/28/73, effective 4/1/73.]

WAC 284-50-080 Preexisting conditions. (1) An advertisement which is subject to the requirements of WAC 284-50-070 shall, in negative terms, disclose the extent to which any loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

(2) When a policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or

medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement if it is an invitation to contract shall disclose that a medical examination is required.

(3) When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question requiring a response by the applicant or a statement in prominent type, all in capital letters, which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question substantially as follows:

"Do you understand that this policy will not pay benefits during the first . . . year(s) after the issue date for a disease or physical condition which you now have or have had in the past?" YES

Or a statement in prominent type, all capitalized, substantially as follows:

"I UNDERSTAND THAT THE POLICY APPLIED FOR WILL NOT PAY BENEFITS FOR ANY LOSS INCURRED DURING THE FIRST . . . YEAR(S) AFTER THE ISSUE DATE ON ACCOUNT OF DISEASE OR PHYSICAL CONDITION WHICH I NOW HAVE OR HAVE HAD IN THE PAST."

[Order R-76-2, § 284-50-080, filed 3/4/76; Order R-73-1, § 284-50-080, filed 2/28/73, effective 4/1/73.]

WAC 284-50-090 Disclosure of provisions relating to renewability, cancellability, and termination. When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

[Order R-76-2, § 284-50-090, filed 3/4/76; Order R-73-1, § 284-50-090, filed 2/28/73, effective 4/1/73.]

WAC 284-50-100 Testimonials or endorsements by third parties. (1) Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement is subject to all the provisions of these rules.

(2) If the person making a testimonial, an endorsement, or an appraisal has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial, endorsement, or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid

endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for television or radio performance. The payment of substantial amounts, directly or indirectly for "travel and entertainment" for filming or recording of television or radio advertisements removes the filming or recording from the category of an unsolicited testimonial and requires disclosure of such compensation. This subsection (2) does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

(3) An advertisement shall not state or imply that any insurer or a policy has been approved or endorsed by an individual, group of individuals, society, association, or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement.

(4) When a testimonial refers to benefits received under a policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-76-2, § 284-50-100, filed 3/4/76; Order R-73-1, § 284-50-100, filed 2/28/73, effective 4/1/73.]

WAC 284-50-110 Use of statistics. (1) An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

(2) An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous," or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for an uncommon claim for the policy advertised is misleading and shall not be used.

(3) The source of any statistics used in an advertisement shall be identified in such advertisement.

[Order R-73-1, § 284-50-110, filed 2/28/73, effective 4/1/73.]

WAC 284-50-120 Identification of plan or number of policies. (1) When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected.

(2) When an advertisement which is an invitation to contract refers to various benefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

[Order R-76-2, § 284-50-120, filed 3/4/76; Order R-73-1, § 284-50-120, filed 2/28/73, effective 4/1/73.]

[Title 284 WAC—page 176]

WAC 284-50-130 Disparaging comparisons and statements. An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services, or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

[Order R-73-1, § 284-50-130, filed 2/28/73, effective 4/1/73.]

WAC 284-50-140 Jurisdictional licensing and status of insurer. (1) An advertisement which reasonably is expected to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

(2) An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this state or the United States government.

[Order R-73-1, § 284-50-140, filed 2/28/73, effective 4/1/73.]

WAC 284-50-150 Identity of insurer. (1) The full legal name (and, where required by RCW 48.30.050, the home office) of the actual insurer shall be shown in each advertisement. The form number or numbers of any specific policy or policies advertised shall be stated in each advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device in a manner which would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

(2) No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color, or other characteristics are so similar to combination of words, symbols, or physical materials, used by agencies of the federal government or of this state, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

[Order R-76-2, § 284-50-150, filed 3/4/76; Order R-73-1, § 284-50-150, filed 2/28/73, effective 4/1/73.]

WAC 284-50-160 Group or quasi-group implications. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

[Order R-73-1, § 284-50-160, filed 2/28/73, effective 4/1/73.]

WAC 284-50-170 Introductory, initial, or special offers. (1) An advertisement of an individual policy shall not directly or by implication represent that a contract or

combination of contracts is an introductory, initial, or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising disability insurance or health care service contractors' agreements.

(2) An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than three months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines, and periodicals, by any one insurer. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control. This rule is inapplicable to solicitations of employees or members of a particular group or association which solicitations are being made under specific provisions of the insurance code for group, blanket, or franchise insurance.

(3) This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

(4) The phrase "a particular insurance product" in subsection (2) of this rule means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for the concurrent or overlapping enrollment periods.

(5) Special awards, such as a "safe driver's award" shall not be used in connection with advertisements of disability insurance.

[Order R-73-1, § 284-50-170, filed 2/28/73, effective 4/1/73.]

WAC 284-50-180 Reduced initial premium rates.

An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which over-emphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

(1995 Ed.)

[Order R-73-1, § 284-50-180, filed 2/28/73, effective 4/1/73.]

WAC 284-50-190 Statements about an insurer. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age, or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

[Order R-73-1, § 284-50-190, filed 2/28/73, effective 4/1/73.]

WAC 284-50-200 Advertising file to be maintained.

Each insurer shall maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to regular and periodical inspection by the insurance commissioner. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

[Order R-73-1, § 284-50-200, filed 2/28/73, effective 4/1/73.]

WAC 284-50-210 Violation defined as unfair practice. A violation of these rules, WAC 284-50-010 through 284-50-230, is hereby defined to be an unfair method of competition and an unfair or deceptive act or practice in the conduct of the business of insurance, pursuant to RCW 48.30.010.

[Order R-73-1, § 284-50-210, filed 2/28/73, effective 4/1/73.]

WAC 284-50-220 Severability provision. If any section or portion of a section of these rules, or the applicability thereof to any person or circumstances is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

[Order R-73-1, § 284-50-220, filed 2/28/73, effective 4/1/73.]

WAC 284-50-230 Effective date. The effective date of this regulation, WAC 284-50-010 through 284-50-230, shall be April 1, 1973.

[Order R-73-1, § 284-50-230, filed 2/28/73, effective 4/1/73.]

MISCELLANEOUS

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).

[Title 284 WAC—page 177]

(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 284-50-270 Mammograms—Coverage requirements and exceptions. (1) The purpose of this regulation is to effectuate the provisions of RCW 48.20.393 and 48.21.225, by establishing definitions for the exceptions to coverage for mammograms. This regulation shall apply to every group and individual disability insurance contract, which is delivered or issued for delivery or renewed in this state on or after September 1, 1992, that provides coverage for hospital or medical expenses.

(2) For the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering specified disease shall be defined to mean and include only those contracts or policies which provide benefits to a policyholder only in the event that the policyholder contracts the disease or diseases specifically named in the policy. Also for the purposes of RCW 48.20.393 and 48.21.225 and this regulation, supplemental contracts covering limited benefits shall be defined to mean and include only those contracts providing only one of the following benefits: Hospital indemnity, accident only coverage, dental care, vision care, mental health care, chemical dependency care, pharmaceutical care, and podiatric care.

(3) Coverage of mammograms may be subject to standard policy provisions applicable to other diagnostic x-ray benefits such as deductible or copayment provisions.

(4) For purposes of RCW 48.20.393 and 48.21.225 and this regulation, a contract is "renewed" when it is continued beyond the earliest date, after September 1, 1992, 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 mammogram coverage, with, if justified, an appropriate rate increase for any increased cost in providing mammogram 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 section is to bring the mammogram coverage 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), 92-19-061 (Order R 92-13), § 284-50-270, filed 9/11/92, effective 10/12/92.]

MINIMUM STANDARDS FOR INDIVIDUAL POLICIES

WAC 284-50-300 Purpose. The purpose of this regulation, WAC 284-50-300 through 284-50-435, is to implement RCW 48.20.450 through 48.20.470 so as to provide reasonable standardization and simplification of terms and coverages of individual disability insurance policies in order to facilitate public understanding and comparison and to eliminate provisions contained in individual disability insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims and to provide for full disclosure in the sale of such coverages.

[Order R-76-4, § 284-50-300, filed 10/29/76, effective 3/1/77.]

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,

(1995 Ed.)

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.]

WAC 284-50-310 Effective date. This regulation shall be effective on March 1, 1977, and shall be applicable to all individual disability insurance policies (except those specifically excluded from the scope of this regulation) delivered or issued for delivery in this state on and after such date: *Provided, however,* That policies which have been approved prior to January 1, 1977, and which are not in compliance with this regulation may be issued until May 1, 1977, unless approval is specifically withdrawn pursuant to RCW 48.18.110.

[Order R-76-4, § 284-50-310, filed 10/29/76, effective 3/1/77.]

WAC 284-50-315 Policy definitions. Except as provided hereinafter, no individual disability insurance policy delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth in this section unless such definitions comply with the requirements of this section.

(1) "One period of confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements due to the same or related causes when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

(2) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

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

(i) Be an institution operated pursuant to law; and

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

(iii) Provide 24 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 emergency basis where a legal liability exists for charges made to the individual for such services.

(3) "Convalescent nursing homes," "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 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(v) Maintains a daily medical record of each patient.

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

(i) Any home, facility or part thereof used primarily for rest;

(ii) A home or facility for the aged or for the care of drug addicts or alcoholics; or

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

(4) "Accident," "accidental injury," "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 injuries, sustained by the insured person which are the direct result of an accident, independent of disease or bodily infirmity or any other cause, and which occur while the insurance is in force.

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided under any worker's 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.

(5) "Sickness" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of any insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days (or 90 days in a cancer only policy) from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any worker's compensation, occupational disease, employer's liability or similar law.

(6) "Preexisting condition" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five year period

preceding the effective date of the coverage of the insured person.

(7) "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.

(8) "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 qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(9) "Total disability" is subject to the following:

(a) A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training or experience and not in fact engaged in any employment or occupation for wage or profit.

(b) Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(i) Perform "any occupation whatsoever," "any occupational duty" or "any and every duty of his occupation," or

(ii) Engage in any training or rehabilitation program.

(c) An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

(10) "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(11) "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

(12) "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I of Public Laws 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the ["Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

(13) "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.

[Order R-76-4, § 284-50-315, filed 10/29/76, effective 3/1/77.]

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

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

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

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

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

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

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

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

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

(f) The insurer provides the commissioner with its assurance that it will promptly notify the insured at such time as the return of premium benefit is not payable to the insured because of the aggregate of claims paid under the policy, together with instructions as to the insured's right and manner of converting to the similar policy or to cancel the rider.

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

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

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

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

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

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

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

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

(iii) Aviation;

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

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

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

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

- (h) Dental care or treatment;
- (i) Eye glasses, hearing aids and examination for the prescription or fitting thereof;
- (j) Rest cures, custodial care, transportation and routine physical examinations;
- (k) Territorial limitations;
- (l) Specified disease and specified accident policies issued in accord with WAC 284-50-365.

(7) Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra-hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required, and use of endorsements is governed by RCW 48.20.015.

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

(9) Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions in accordance with RCW 48.18.110.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-320, filed 12/9/81; Order R-76-4, § 284-50-320, filed 10/29/76, effective 3/1/77.]

WAC 284-50-325 Minimum standards for benefits.

Minimum standards for benefits are prescribed for the categories of coverage noted in WAC 284-50-330 through 284-50-370. No individual disability insurance policy shall be delivered or issued for delivery in this state which does not meet the required minimum standards for its specified category. Nothing in this section shall preclude the issuance of any policy combining two or more categories of coverage.

[Order R-76-4, § 284-50-325, filed 10/29/76, effective 3/1/77.]

WAC 284-50-330 General rules as to minimum standards. (1) A "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

(2) The terms "noncancellable," "guaranteed renewable" or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of WAC 284-50-375(1). The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: *Provided, however*, any accident and health or accident only policy

which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: *Provided, however*, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60, if at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

(3) In a family policy covering both husband and wife the age of the younger spouse may be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

(4) When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

(5) If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

(6) In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

(7) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility with a period of less than fourteen days after discharge from the hospital.

(8) In accord with RCW 48.20.420, coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap, on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children, and who is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of such date the company receive due proof of such incapacity and dependency in order for the insured to elect to continue the policy in force with respect to such child, or that a separate converted policy be issued at the option of the insured or policyholder.

(9) Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

(10) A policy may contain a provision relating to recurrent disabilities; provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six months.

(11) Accidental death and dismemberment benefits shall be payable if the loss occurs within no less than ninety days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

(14) All Medicare supplement policies providing in-hospital benefits only shall include in their provided benefits the initial Part A Medicare deductible as established from time to time by the Social Security Administration. Premiums may be reduced or raised to correspond with changes in the covered deductible.

(15) Termination of the 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 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.

(16) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every individual disability insurance policy or contract issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice, or home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

(a) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice, and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(b) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending

physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(c) An insurer may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(d) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the policy or contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's policy or contract.

(e) This subsection shall not apply to long-term care, Medicare supplement, or disability income protection insurance policies or contracts. This subsection shall not apply to guaranteed renewable disability insurance policies or contracts issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. 94-19-015 (Order R 94-16), § 284-50-330, filed 9/9/94, effective 10/10/94; Order R-76-4, § 284-50-330, filed 10/29/76, effective 3/1/77.]

WAC 284-50-335 Basic hospital expense coverage.

"Basic hospital expense coverage" is a policy of disability insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

(1) Daily hospital room and board in an amount not less than the lesser of 80% of the charges for semi-private room accommodations or \$50 per day;

(2) Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during the period of confinement in an amount not less than either 80% of the charges incurred up to at least \$1,000 or ten times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(a) Hospital services on the day surgery is performed, and accidental injury, in an amount not less than \$50; and

(b) Hospital services rendered within 72 hours after accidental injury, in an amount not less than \$50; and

(c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than \$100 if rendered to an in-patient of the hospital.

(4) Benefits provided under subsections (1) and (2) of this section may be provided subject to a combined deductible amount not in excess of \$100.

[Order R-76-4, § 284-50-335, filed 10/29/76, effective 3/1/77.]

WAC 284-50-340 Basic medical-surgical expense coverage. "Basic medical-surgical expense coverage" is a policy of disability insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician

for treatment of an injury or sickness for at least the following:

(1) Surgical services:

(a) In amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1974 California relative value schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$500 for any one procedure; or

(b) Not less than 80% of the reasonable charges.

(2) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a person licensed to perform such service other than the physician (or his assistant) performing the surgical services:

(a) In an amount not less than 80% of the reasonable charges; or

(b) 15% of the surgical service benefit.

(3) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or \$5 per day for not less than 21 days during one period of confinement.

[Order R-76-4, § 284-50-340, filed 10/29/76, effective 3/1/77.]

WAC 284-50-345 Hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" is a policy of disability insurance which principally provides daily benefits for hospital confinement on an indemnity basis in an amount not less than \$10 per day and not less than 31 days during any one period of confinement for each person insured under the policy. Additional benefits may be provided in such policy.

[Order R-76-4, § 284-50-345, filed 10/29/76, effective 3/1/77.]

WAC 284-50-350 Major medical expense coverage.

(1) "Major medical expense coverage" is a disability insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$10,000; copayment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefit provided by such underlying insurance, provided the policy containing such deductible meets the criteria of subsection (3) of this rule.

(2) The coverage for each covered person shall be for at least:

(a) Daily hospital room and board expenses, prior to application of the copayment percentage, for not less than \$50 daily (or in lieu thereof the average daily cost of semiprivate room rate in the area where the insured resides) for a period of not less than 31 days during continuous hospital confinement;

(b) Miscellaneous hospital services, prior to application of the copayment percentage, for an aggregate maximum of

not less than the greater of \$1,500 or 15 times the daily room and board rate if specified in dollar amounts;

(c) Surgical services, prior to application of the copayment percentage, to a maximum of not less than \$600 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

(d) Anesthesia services, prior to application of the copayment percentage, for a maximum of not less than 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

(e) In-hospital medical services, prior to application of the copayment percentage, as defined in WAC 284-50-340(3).

(f) Out of hospital care, prior to application of the copayment percentage, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(g) Not fewer than three of the following additional benefits, prior to application of the copayment percentage, for an aggregate maximum of such covered charges of not less than \$1,000:

(i) In-hospital private duty graduate registered nurse services;

(ii) Convalescent nursing home care;

(iii) Diagnosis and treatment by a radiologist or physiotherapist;

(iv) Rental of special medical equipment, as defined by the insurer in the policy;

(v) Artificial limbs or eyes, casts, splints, trusses or braces;

(vi) Treatment for functional nervous disorders, and mental and emotional disorders;

(vii) Out-of-hospital prescription drugs and medications.

(3) The "variable deductible" permitted by subsection (1) of this rule will not be approved unless the following conditions are met:

(a) The policy containing such deductible shall be either guaranteed renewable as defined in WAC 284-50-330 or be a policy which would otherwise be so guaranteed renewable except that the insurer has reserved the right to terminate all such policies in this state.

(b) The policy containing such deductible shall provide that the policyholder shall have the right to increase the stated or specified deductible on any policy anniversary date or upon the establishment of a benefit period, as defined in the policy.

(c) An insurer intending to market such policies in this state shall provide the commissioner, as part of its filing of policy forms, the following information and assurances:

(i) The outline of coverage used in connection with the policy shall contain a clear and prominent explanation of the effect of the variable deductible with respect to other coverages;

(ii) In the event a claim situation arises where the operation of the deductible provision would result in payment to the insured of an amount less than the total covered

expenses for which the insured has not been reimbursed under other policies, the variable deductible feature of the deductible provision will be disregarded to the extent necessary to provide payment for such nonreimbursed expenses, subject to the variable deductible policy's coinsurance percentage;

(iii) An annual notice will be given to the policyholder recommending a review of the policy and the deductible feature in light of any change in the policyholder's other coverage which might affect the policy. A copy of such notice shall be filed with the commissioner prior to use.

[Order R-76-4, § 284-50-350, filed 10/29/76, effective 3/1/77.]

WAC 284-50-355 Disability income protection coverage. (1) "Disability income protection coverage" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

(a) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to age 62.

(b) Contains an elimination period no greater than:

(i) Ninety days in the case of coverage providing a benefit of one year or less;

(ii) One hundred eighty days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(iii) Three hundred sixty-five days in all other cases during the continuance of disability resulting from sickness or injury.

(c) Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth, or miscarriage in which case the period for such disability may be one month.

(2) No disability income protection policy shall contain any provision permitting a reduction in benefits because of an increase in Social Security benefits.

(3) This section does not apply to those policies providing business buyout coverage.

[Order R-76-4, § 284-50-355, filed 10/29/76, effective 3/1/77.]

WAC 284-50-360 Accident only coverage. "Accident only coverage" is a policy of accident insurance which provides coverage, singly or combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

[Order R-76-4, § 284-50-360, filed 10/29/76, effective 3/1/77.]

WAC 284-50-365 Specified disease and specified accident coverage. (1) "Specified disease coverage" is a policy which meets one of the following definitions:

(a) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount not in excess of \$250 and an overall aggregate benefit limit of no less than \$5,000 and

a benefit period of not less than two years for at least the following incurred expenses:

(i) Hospital room and board and any other hospital furnished medical services or supplies;

(ii) Treatment by a legally qualified physician or surgeon;

(iii) Private duty services of a registered nurse (R.N.);

(iv) X-ray, radium and other therapy procedures used in diagnosis and treatment;

(v) Professional ambulance for local service to or from a local hospital;

(vi) Blood transfusions, including expense incurred for blood donors;

(vii) Drugs and medicines prescribed by a physician;

(viii) The rental of an iron lung or similar mechanical apparatus;

(ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

(x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

(xi) May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(b) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined in a hospital and a benefit period of not less than 500 days.

(2) "Specified accident coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than \$1,000 for accidental death; \$1,000 for double dismemberment and \$500 for single dismemberment.

[Order R-76-4, § 284-50-365, filed 10/29/76, effective 3/1/77.]

WAC 284-50-370 Limited benefit health insurance coverage. "Limited benefit health insurance coverage" is any policy which provides benefits that are less than the minimum standards for benefits required under WAC 284-50-335 through 284-50-365, and which the commissioner approves as being in the public interest. Such policies may be delivered or issued for delivery in this state only if the outline of coverage required by WAC 284-50-425 is completed and delivered as required by WAC 284-50-380.

[Order R-76-4, § 284-50-370, filed 10/29/76, effective 3/1/77.]

WAC 284-50-375 Required disclosure provisions, general rules. (1) Each individual disability insurance policy shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear or bear a prominent reference thereto on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law.

(3) Where a separate additional premium is charged for benefits provided in connection with a rider or endorsement, such premium charge shall be set forth in the policy.

(4) A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(5) If a policy contains any limitations with respect to preexisting conditions such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(6) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."

(7) All policies, except single premium nonrenewable policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

(8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

(9) If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion (including those with respect to the reimposition of a time limit on certain defenses provision), and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

[Order R-76-4, § 284-50-375, filed 10/29/76, effective 3/1/77.]

WAC 284-50-377 Experimental and investigational prescriptions, treatments, procedures, or service—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every individual disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits

for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the individual disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy. As an example, and not by way of limitation, the requirement to set forth criteria in the policy may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every individual disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every individual disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The individual disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the individual disability insurer in each policy which contains an experimental or investigational exclusion or limitation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. 92-21-101 (Order R 92-17), § 284-50-377, filed 10/21/92, effective 11/21/92.]

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

(a) Is either delivered with the policy; or

(b) Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

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

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

340, and 284-50-350 shall be the statement contained in WAC 284-50-405.

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

(5) Outlines of coverage delivered in connection with policies defined in this regulation as hospital confinement indemnity (WAC 284-50-345), Specified disease (WAC 284-50-365), or Limited benefit health insurance coverages (WAC 284-50-370) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of WAC 284-50-400, 284-50-420 and 284-50-425, the following language which shall be printed or stamped on or attached to the first page of the outline of coverage: "**This policy is not a Medicare supplement policy.** If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide* available from the company." Such notice shall be in no less than twelve point type.

[Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-50-380, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-017 (Order R 81-7), § 284-50-380, filed 12/9/81; Order R-76-4, § 284-50-380, filed 10/29/76, effective 3/1/77.]

WAC 284-50-385 Basic hospital expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335.

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE -
OUTLINE OF 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) **Basic hospital expense coverage** - Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or *unlimited* hospital expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained in *this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services; and
- (d) Other benefits, if any.)

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any

other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-385, filed 10/29/76, effective 3/1/77.]

WAC 284-50-390 Basic medical-surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-340.

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF 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) **Basic medical-surgical expense coverage** - Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts and number of days duration where applicable, contained *in this* policy, in the following order:

- (a) Surgical services;
- (b) Anesthesia services;
- (c) In-hospital medical services; and
- (d) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-390, filed 10/29/76, effective 3/1/77.]

WAC 284-50-395 Basic hospital and medical surgical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-335 and 284-50-340.

(COMPANY NAME)

BASIC HOSPITAL AND
MEDICAL SURGICAL EXPENSE COVERAGE
OUTLINE OF 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) **Basic hospital and medical surgical expense coverage** - Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for *unlimited* hospital or medical-surgical expenses.

(3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained *in this policy*, in the following order:

- (a) Daily hospital room and board;
- (b) Miscellaneous hospital services;
- (c) Hospital outpatient services;
- (d) Surgical services;
- (e) Anesthesia services;
- (f) In-hospital medical services; and
- (g) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-395, filed 10/29/76, effective 3/1/77.]

WAC 284-50-400 Hospital confinement indemnity coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-345.

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE
OUTLINE OF 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) **Hospital confinement indemnity coverage** - Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during period of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(3) (A brief *specific* description of the benefits contained in *this policy*, in the following order:

(a) Daily benefit payable during hospital confinement; and

(b) Duration of benefit described in (a).

(c) Any benefits provided in addition to the daily hospital benefit.

(Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-400, filed 10/29/76, effective 3/1/77.]

WAC 284-50-405 Major medical expense coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-350.

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF 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) **Major medical expense coverage** - Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*, in the following order:

(a) Daily hospital room and board;

(b) Miscellaneous hospital services;

(c) Surgical services;

(d) Anesthesia services;

(e) In-hospital medical services;

(f) Out of hospital care;

(g) Maximum dollar amount for covered charges; and

(h) Other benefits, if any.

(Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-405, filed 10/29/76, effective 3/1/77.]

WAC 284-50-410 Disability income protection coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-355.

(COMPANY NAME)

DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF 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) **Disability income protection coverage** - Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-410, filed 10/29/76, effective 3/1/77.]

WAC 284-50-415 Accident only coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-360.

(COMPANY NAME)

ACCIDENT ONLY COVERAGE
OUTLINE OF 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) **Accident only coverage** - Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident *only*, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13) of this regulation.)

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-415, filed 10/29/76, effective 3/1/77.]

WAC 284-50-420 Specified disease or specified accident coverage, outline of coverage. An outline of coverage in substantially the following form, shall be issued in connection with policies meeting the standards of WAC 284-50-365.

(COMPANY NAME)

(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF 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) **(Specified disease) (specified accident) coverage** - Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits *only* when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major-medical expenses.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*:

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with WAC 284-50-325(13).

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-420, filed 10/29/76, effective 3/1/77.]

WAC 284-50-425 Limited benefit health coverage, outline of coverage. An outline of coverage, in substantially the following form, shall be issued in connection with policies which do not meet the minimum standards of WAC 284-50-335 through 284-50-365.

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF 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) **Limited benefit health coverage** - Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

(3) (A brief *specific* description of the benefits, including dollar amounts, contained in *this policy*.)

Note: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (13) of WAC 284-50-330.

(4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

(5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

[Order R-76-4, § 284-50-425, filed 10/29/76, effective 3/1/77.]

WAC 284-50-430 Requirements for replacement.

(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other disability insurance 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, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (3) of this section. One copy of such notice shall be retained by 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 upon issuance of the policy, the notice described in subsection (4) of this section. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

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. 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 interests 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 has 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)

(Applicants' Signature)

(4) The notice required by subsection (2) of this section, for a direct response insurer, shall be as follows:

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). Your new policy provides 10 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, 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 interests 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 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

(5) The required notice may be modified if preexisting conditions are covered under the new policy.

[Order R-76-4, § 284-50-430, filed 10/29/76, effective 3/1/77.]

WAC 284-50-435 Separability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

[Order R-76-4, § 284-50-435, filed 10/29/76, effective 3/1/77.]

Chapter 284-51 WAC STANDARDS FOR COORDINATION OF BENEFITS

WAC

Table with 2 columns: WAC number and description. Includes items like 284-51-010 Purpose and scope, 284-51-015 Amount of reduction allowed, 284-51-020 Required provisions for coordination of benefits, etc.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

284-51-070	Order of benefit determination. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-070, filed 6/18/81, effective 1/1/82.] Repealed by 94-20-068, (Order R 94-15), filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a).
284-51-160	Conformity of contracts. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-160, filed 6/18/81, effective 1/1/82.] Repealed by 94-20-068, (Order R 94-15), filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a).

WAC 284-51-010 Purpose and scope. (1) This regulation, WAC 284-51-010 through 284-51-180, is adopted pursuant to RCW 48.21.200 to establish standard coordination of benefit provisions, and uniform guidelines for their interpretation and administration, for group and individual disability insurance policies (as defined in RCW 48.20.002 and 48.21.010), group and individual health care service contracts and group and individual health maintenance organization agreements (all of which are hereinafter referred to as "health contracts"), whose hospital, medical, or surgical benefits may be reduced because of other existing coverages. This regulation applies to individual and group contracts delivered or issued for delivery in Washington state. Except where the context otherwise requires, the definitions given in the Washington Insurance Code, Title 48 RCW, govern the construction of this regulation.

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

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

(4) For purposes of this regulation, the words "medical benefits" shall be broadly construed and shall include, but not be limited to dental, optical, prescription drug and audio benefits.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-010, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-010, filed 6/18/81, effective 1/1/82.]

WAC 284-51-015 Amount of reduction allowed. (1) As to benefits for preventive care, no health contract which is allowed to reduce or refuse to pay its benefits hereunder and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses.

(2) As to benefits which are not for preventive care, no contract which is allowed to reduce or refuse to pay its

benefits hereunder and which contains a provision for the reduction of benefits otherwise payable or available thereunder on the basis of other existing coverages shall provide that such reduction will operate to reduce total benefits payable below an amount equal to one hundred percent of total allowable expenses exclusive of copayments, deductibles, and other similar cost-sharing arrangements. When out-of-pocket costs to the consumer reach two-hundred-fifty-dollars in a given calendar year over that carrier's deductible amount, if any, then coordination of benefits which are not for preventive care shall be done, if at all, in the manner prescribed in subsection (1) of this section.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-015, filed 10/3/94, effective 11/3/94.]

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

(2) A blanket disability insurance policy, as defined in RCW 48.21.040, is not within the scope of this regulation, thus it may include an "excess" or "nonduplication of benefits" provision.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-020, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-020, filed 6/18/81, effective 1/1/82.]

WAC 284-51-030 Benefits subject to coordination. (1) A health contract which provides for coordination of all benefits thereunder shall contain a provision as follows: "**Benefits subject to this provision:** All of the benefits provided under this policy are subject to this provision."

(2) If one or more of the health contract benefits are to be exempt from reduction under the coordination provision, appropriate changes shall be made in the wording set forth in subsection (1). For example: "Only the major medical expense benefits provided under this policy are subject to this provision."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-030, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-030, filed 6/18/81, effective 1/1/82.]

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

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

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

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

(c) Governmental programs; and

(d) Coverage required or provided by any statute.

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

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

(5) The definition of a "Plan" may not include group hospital indemnity benefits (that is, benefits paid on other than an expense incurred basis) of \$200 per day or less. It may, however, include reimbursement-type benefits where the insured has the right to elect indemnity-type benefits in lieu of the reimbursement benefits at the time of claim. The amount of group hospital indemnity benefits which exceeds \$200 per day may be included in the definition of "Plan."

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

(7) The definition of a "Plan" may include automobile insurance policies required by statute to provide medical benefits.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-040, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-040, filed 6/18/81, effective 1/1/82.]

WAC 284-51-045 "Preventive care" defined. For purposes of this chapter, "preventive care" means "examinations, well baby care and other outpatient services specifically provided to monitor and maintain the patient's health and/or to prevent illness."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-045, filed 10/3/94, effective 11/3/94.]

WAC 284-51-050 Allowable expense. (1) A health contract which provides for coordination of benefits ("COB") shall contain a provision stating what expenses are to be recognized under the coordination provision as an allowable expense.

(a) Each such health contract shall include the following definition: "Allowable expense means the (usual, customary

and reasonable) charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the covered person's stay in a private hospital room is considered medically necessary under at least one of the plans involved."

(b) Notwithstanding the above definition, health care services or supplies under plans which are limited to providing coverages such as dental care, vision care, prescription drugs or hearing aids may limit the definition of allowable expense. A plan which provides benefits only for any such health care services or supplies may limit its definition of allowable expense to like services or supplies.

(c) When COB is restricted in its use to specific benefits in a health contract (for example, major medical or dental benefits, only), the definition of allowable expense must include the corresponding services and supplies to which COB applies.

(2) A plan is not required to include language in its health contracts which is substantially similar to subsections (3) through (8) of this section. However, it may not include language which conflicts with subsections (3) through (8) of this section. COB adjudication practices must reflect subsections (3) or (4) or (5), and (6) and (7) and (8) of this section.

(3) When a plan provides benefits in the form of cash payments rather than services or supplies, the allowable expense may be the lesser of either the provider's charge for a health care service or supply, or the "usual, customary and reasonable" charge for that particular health care service or supply. In lieu of "usual, customary and reasonable," a plan may substitute the terms "usual and prevailing," or "reasonable and customary," or other terms which are commonly understood to be similar in meaning. A plan may only limit allowable expense to the "usual, customary and reasonable" charge if:

(a) That term is reasonably defined in that insurer's health contract. Prior to limiting an allowable expense to a "usual, customary and reasonable" charge, the insurer must be able to support that such a limitation is based upon the application of statistically reliable comparative statistical measures, and is regularly reevaluated based on data which is current within twelve months of the date the service or supply was provided. When a secondary plan's "usual, customary and reasonable" charge for a particular health care service or supply is less than the primary plan's "usual, customary and reasonable" charge for that same health care service or supply, the secondary plan must coordinate benefits based on no less than the primary plan's "usual, customary and reasonable" charge for that health care service or supply; or

(b) The health care service or supply is a covered benefit under the primary plan and the primary plan limits its allowable expense to the "usual, customary and reasonable" charge in accordance with (a) of this subsection: *And provided further*, That the secondary plan excludes that

service or supply in the absence of COB. In such case, the secondary plan may coordinate benefits for that service or supply based on the primary plan's "usual, customary and reasonable" charge.

(4)(a) A plan may provide benefits in the form of services or supplies rather than cash payments. Services or supplies may be provided directly by the insurer, or they may be provided through various contractual arrangements between providers and the insurer which involve the payment of negotiated amounts based on fee schedules, percentage discounts off of a provider's usual charge, per diem payments, case price payments, or other substantially similar types of negotiated arrangements.

(b) For the purposes of this subsection (4) of this section, when services or supplies are provided through a contractual arrangement between the provider and the insurer in exchange for payment of a negotiated amount to the provider, the "negotiated amount" shall mean the amount set forth in the contractual arrangement in effect at the time of service. Such contractual arrangements must specify that the provider agrees to accept such amount as payment in full for a covered health care service or supply provided to a person enrolled under a group contract issued by that insurer.

(c) If the provider agrees to accept the negotiated amount as payment in full, whether that amount is paid in whole or in part by the covered person, or by that insurer, or by any combination of payors including other insurers which pay before that insurer in the order of benefit determination, then and only then may the insurer which is a party to that contractual arrangement with the provider consider the negotiated amount as the allowable expense. An insurer may not consider amounts negotiated in a contractual arrangement to which it is not a party to be the allowable expense.

(i) When the covered person is not responsible for paying any portion of the negotiated amount, and the insurer pays the entire negotiated amount to the provider, then that insurer may consider the negotiated amount as both an allowable expense and a benefit paid.

(ii) When any portion of the negotiated amount is paid by the covered person in accordance with the health contract issued by the insurer, or is paid by any other person including any other insurer, then the negotiated amount may be considered the allowable expense. The negotiated amount less any amounts payable by other persons, including the covered person, shall be considered the benefit paid.

(5) When services or supplies are provided directly by the insurer, the reasonable cash value of the health care service or supply shall be considered the allowable expense. When the covered person is not responsible for paying any portion of the allowable expense, that insurer may consider the reasonable cash value of the health care service or supply as both an allowable expense and a benefit paid. When the covered person is responsible for paying any portion of the allowable expense in accordance with the insurer's group contract covering the enrolled person, the reasonable cash value may be considered the allowable expense but the reasonable cash value less any amounts payable by other persons including the covered person shall be considered the benefit paid.

(6) The inclusion of Medicare or similar governmental benefits in the definition of a plan will not require the

definition of allowable expense to recognize governmental benefits other than hospital, medical and surgical benefits.

(7) "Total allowable expenses" shall mean the sum of all allowable expenses for a particular covered person for a particular claim determination period. A secondary plan may reduce its benefits so that the total benefits paid or total services and supplies provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced (that plan's COB savings) shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the covered person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay or provide for allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

(8) When a secondary plan provides a benefit in the form of services or supplies through a contractual arrangement between the provider and the insurer rather than in the form of a cash payment, and that plan's allowable expense is less than the amount of the payment provided by any primary plan for that service or supply, the secondary plan shall not consider the primary plan's benefit to be more than the secondary plan's allowable expense for that service or supply for the purpose of determining total allowable expenses. In no event should a deficit amount be credited to the total allowable expenses because the primary plan's benefit payment exceeded the secondary plan's allowable expense.

(9) In the case where coverage is provided through internal maximums in the contract, the secondary carrier must coordinate benefits in such a manner to allow coverage for the internal maximums provided for in both the primary contract and the secondary contract. If internal maximums are provided for by a specified maximum dollar amount then the secondary carrier must coordinate benefits as secondary carrier until benefits under the primary contract are exhausted then pay its own contract benefits (up to its internal maximum dollar amount) until its own benefits are exhausted. If internal maximums are provided for by a specified maximum number of visits then the secondary carrier must coordinate benefits as secondary carrier until benefits under the primary contract are exhausted then pay its own contract benefits (up to its own maximum) until its own benefits are exhausted.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-050, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. 91-18-026 (Order R 91-6), § 284-51-050, filed 8/23/91, effective 9/23/91. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-050, filed 6/18/81, effective 1/1/82.]

WAC 284-51-060 Claim determination period. A health contract which provides for coordination of benefits shall contain a provision stating the period to be used in applying the coordination provision, as follows: "**Claim determination period:** 'Claim determination period' means calendar year."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-060, filed 10/3/94, effective

11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-060, filed 6/18/81, effective 1/1/82.]

WAC 284-51-075 Order of benefit determination.

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

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.

(b) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this subsection regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this subsection shall not apply, and the rule set forth in the plan which does not have the provisions of this subsection shall determine the order of benefits. In the case of a person for whom claim is made as a dependent child, however,

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

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

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

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

(i) The benefits of a plan covering the person on whose expenses claim is based as a laid off or retired employee, or

dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid off or retired employee, or dependent of such person;

(ii) If either plan does not have a provision regarding laid off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (i) of this subsection shall not apply.

(d) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.

(2) If the health contract provides more than one benefit, the health contract shall contain a provision stating how the reduction in benefits by the coordination provision affects each benefit under the health contract. Suggested language for such provision is included in Appendix B, WAC 284-51-185.

(3) A group contract which provides for coordination of benefits shall contain a provision entitled "*Effect on Benefits*," stating the manner in which benefits are reduced by coordination, which provision shall be substantially as set forth in Appendix B, WAC 284-51-185.

(4) This section takes effect on January 1, 1987. The provisions of this section shall apply to all policy and contract forms subject to this section that are issued on or after this effective date, and all policy and contract forms that were issued prior to said effective date shall be brought into compliance with the requirements of this section by the later of the next anniversary date or renewal date of the group policy or contract, or the expiration of any applicable collectively bargained contract pursuant to which they are written.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-075, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-075, filed 11/4/86, effective 1/1/87.]

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

(1) In determining the length of time a person in a given group has been covered under a given plan, two successive plans covering the group shall be considered one continuous plan if the person was eligible for the coverage under the second plan within 24 hours after the first plan terminated. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not of itself constitute the start of a new plan for purposes of WAC 284-51-070 (1)(c).

(2) If a person's effective date of coverage under a plan is subsequent to the date the carrier first contracted to provide the plan for the group concerned, the carrier shall assume for purposes of WAC 284-51-070 (1)(c), in the absence of specific information to the contrary, that the person's length of time covered under the plan is measured from his effective date of coverage. If a person's effective date of coverage under a plan is the same as the date the carrier first contracted to provide the plan for the group concerned, the carrier shall request the group to furnish the

date the person first became covered under the earliest of any prior plans the group may have had. If such date is not furnished, the date the person first became a member of the group shall be used as the date from which to determine the length of time his coverage under the plan has been in force.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-080, filed 6/18/81, effective 1/1/82.]

WAC 284-51-090 Coordination procedures.

Insurers shall use the following claims administration procedures to expedite the claim payments where coordination of benefits is involved:

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

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

(3) Insurers shall consider building a local data file with at least basic information on group health plans for major employers in the local area.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-090, filed 6/18/81, effective 1/1/82.]

WAC 284-51-100 Time limit.

No insurer shall unreasonably delay payment of a claim by reason of the application of a coordination of benefits provision. Each insurer shall establish a time limit after which payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage shall be conducted concurrently, so as to create no further delay in the ultimate payment of benefits. If an insurer is required by the time limit to make payment as the primary plan because it then has insufficient information to make it a secondary plan, it may exercise its rights under its "right of recovery" provision to recover any excess payments made thereby.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-100, filed 6/18/81, effective 1/1/82.]

WAC 284-51-110 Small claim waivers.

In appropriate cases, insurers are encouraged to waive the investigation of possible other plan coverage on claims less than \$50, but if additional liability is incurred which raises the claim above \$50, the entire liability may be included in the coordination of benefits computation.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-110, filed 6/18/81, effective 1/1/82.]

WAC 284-51-120 Facility of payment.

A health contract which provides for coordination of benefits shall contain a provision substantially as follows: "**Facility of payment:** Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, the insurer shall have the right, exercisable alone and in its sole discretion, to pay over

to any Plan making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be considered benefits paid under this Plan and, to the extent of such payments, the insurer shall be fully discharged from liability under this Plan."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-120, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-120, filed 6/18/81, effective 1/1/82.]

WAC 284-51-130 Right of recovery.

A health contract which provides for coordination of benefits shall contain a provision substantially as follows: "**Right of recovery:** Whenever payments have been made by the insurer with respect to allowable expenses in total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the insurer shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the insurer shall determine: Any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any other organizations or other Plans."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-130, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-130, filed 6/18/81, effective 1/1/82.]

WAC 284-51-140 Right to receive and release necessary information.

A health contract which provides for coordination of benefits may contain a provision substantially as follows: "**Right to receive and release necessary information:** For the purpose of determining the applicability of and implementing this provision and any provision of similar purpose in any other Plan, the insurer may, with such consent of the insured person as may be necessary, release to or obtain from any other insurer, organization or person any information, with respect to any person, which the insurer considers necessary for such purpose. Any person claiming benefits under this Plan shall furnish to the insurer the information necessary for such purpose."

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-140, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-140, filed 6/18/81, effective 1/1/82.]

WAC 284-51-150 Disclosure of coordination.

(1) Each certificate of coverage under a health contract which provides for coordination of benefits must contain, at least in summary form, a description of the coordination provision.

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

(3) In addition, each insurer shall urge its group clients to take reasonable steps so that those insured by the group policy are exposed to reasonably concise explanations, with as little technical terminology as is consistent with accuracy,

of the purpose and operation of the coordination of benefits provision. Such educational effort may, for example, take the form of articles in company magazines or newspapers, speeches before labor organizations or other employee groups, brochures in pay envelopes, notices on bulletin boards and materials used by employers in counseling employees.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-150, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-150, filed 6/18/81, effective 1/1/82.]

WAC 284-51-170 Effective date. This regulation, WAC 284-51-010 through 284-51-180, shall take effect January 1, 1995.

[Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-170, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-170, filed 6/18/81, effective 1/1/82.]

WAC 284-51-180 Appendix A, form for "effect on benefits" provision. Effect on benefits:

(1) This provision shall apply in determining the benefits for a person covered under this Plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

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

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

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

(3) If

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

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

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

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

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

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

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

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

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

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

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-180, filed 6/18/81, effective 1/1/82.]

WAC 284-51-185 Appendix B, form for "effect on benefits" provision. Effect on benefits:

(1) This provision shall apply in determining the benefits for a person covered under this plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

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

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

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

(3) If

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

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

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

(a) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.

(b) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this subsection regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this subsection shall not apply, and the rule set forth in the plan which does not have the provisions of this subsection shall determine the order of benefits. In the case of a person for whom claim is made as a dependent child, however,

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

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

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

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

(i) The benefits of a plan covering the person on whose expenses claim is based as a laid off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid off or retired employee, or dependent of such person; and

(ii) If either plan does not have a provision regarding laid off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (i) of this subsection shall not apply.

(d) If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member, or subscriber longer are determined before those of the plan which covered that person for the shorter time.

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

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this plan.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-185, filed 11/4/86, effective 1/1/87.]

Chapter 284-52 WAC

CONVERSION REGULATION

WAC

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

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

(2) Other conversion plans in addition to those required by this chapter may also be offered.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-010, filed 9/19/84.]

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

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

(3) Such conversion benefit plans:

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

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

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

(d) May be rated based upon attained age.

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

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

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

(h) Which are written to cover all members of a family under one contract, shall contain a provision to assure that each member, in the event that he or she ceases to be a qualified family member for purposes of coverage, as, for example, by attaining a particular age, or through a marriage or a divorce, or by reason of death of the principal covered person, shall have the right to continue the coverage without a physical examination, statement of health, or other proof of insurability.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-020, filed 9/19/84.]

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

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

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

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

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

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

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

(4) Be administered by the carrier in full compliance with any applicable laws which prohibit denials of payments for services performed by certain licensed providers of service.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-030, filed 9/19/84.]

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

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

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

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

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

(5) Usual and customary assistant surgeons' fees.

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

(7) Inpatient and outpatient physician services at the usual and customary charge.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-040, filed 9/19/84.]

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

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

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

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

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthesiologists' fees.

(f) Inpatient and outpatient physician services.

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

WAC 284-52-060 Comprehensive medical plan.

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

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

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

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

(b) Ancillary hospital expenses.

(c) Surgeons' fees.

(d) Assistant surgeons' fees.

(e) Anesthesiologists' and anesthesiologists' fees.

(f) Inpatient and outpatient physician services.

(3) A health maintenance organization's comprehensive medical plan may provide for no deductible amount or a deductible in any amount not exceeding five hundred dollars.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 85-03-035 (Order R 85-1), § 284-52-060, filed 1/10/85; 84-19-055 (Order R 84-4), § 284-52-060, filed 9/19/84.]

WAC 284-52-070 Exclusions.

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

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

(2) Pregnancy, except for complications of pregnancy.

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

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

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

(c) Aviation.

(4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows covered surgery resulting from trauma, infection or other diseases of the involved part, reconstructive breast surgery covered pursuant to RCW 48.20.395, 48.21.230, 48.44.330 and 48.46.280, and recon-

structive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

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

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

(7) Dental care or treatment.

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

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

(10) Territorial limitations.

(11) Other exclusions commonly used by the particular carrier in group contracts providing hospital or medical benefits to employee groups.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 84-19-055 (Order R 84-4), § 284-52-070, filed 9/19/84.]

Chapter 284-53 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

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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.

(10) "Adult day health care" means a program of community based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the individual's home.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-020, filed 7/6/94, effective 8/6/94. 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 institu-

tional 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) A long-term care contract must cover skilled, intermediate, and custodial or personal care, whether benefits are for institutional or community based care.

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

(6) No insurer may offer a contract form which requires prior skilled or intermediate care as a condition of coverage for institutional or community based care.

(7) No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.

(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, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-150, filed 7/6/94, effective 8/6/94. 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 284-54-200 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance contract or certificate replaces another long-term care insurance contract or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care insurance contract for similar benefits to the extent that similar exclusions have been satisfied under the original contract.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-200, filed 7/6/94, effective 8/6/94.]

WAC 284-54-210 Minimum standards for community based care benefits in long-term care insurance policies. (1) No long-term care insurance contract or certificate which provides benefits for community based care services may limit or exclude benefits:

(a) By requiring care in a skilled nursing facility before covering community based care services;

(b) By requiring that the insured first or simultaneously receive nursing or therapeutic services in a home, community or institutional setting before community based care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that community based care services may be delivered only by licensed nurses or therapists when the type of services to be provided comes within the authorized scope of license of other regulated health care providers;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the delivery of community based care services be at a level of certification or licensure greater than that required for the eligible service;

(g) By requiring that the insured have an acute condition before community based care services are covered;

(h) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) A long-term care insurance contract or certificate, if it provides for community based care services, shall provide coverage for total community based care services in a dollar amount equivalent to at least one-half of one year's coverage available for institutional benefits under the contract or certificate at the time covered community based care services are received. This requirement does not apply to contracts or certificates issued to residents of continuing care retirement communities.

(3) Community based care coverage may be applied to the nonhome health care benefits provided in the contract or certificate when determining maximum coverage under the terms of the contract or certificate.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-210, filed 7/6/94, effective 8/6/94.]

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 284-54-260 Extension of benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any applicable waiting period, and all other applicable provisions of the contract or certificate.

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-260, filed 7/6/94, effective 8/6/94.]

WAC 284-54-270 Requirement to offer inflation protection. (1) No insurer may offer a long-term care insurance contract unless, in addition to any other inflation protection option, the insurer offers to the applicant the option to purchase a contract that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the contract. Insurers must offer to each applicant, at the time of purchase, the option to purchase a contract with an inflation protection feature no less favorable than one of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the contract is issued to a group, the required offer in subsection (1) of this section shall be made to the group policyholder; except, if the policy is issued to an association group (defined in RCW 48.24.045) other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in subsection (1) of this section shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(4) Insurers shall include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a contract that increases benefits over the contract period with

a contract that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(c) It is intended that meaningful inflation protection be provided. Meaningful benefit minimums or durations may, for example, include providing increases to attained age, or for a period such as at least twenty years, or for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a contract which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the contract.

(6) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section shall be included in a long-term care insurance contract unless an insurer obtains a written rejection of inflation protection signed by the applicant.

(b) The rejection shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this contract with and without inflation protection. Specifically, I have reviewed Plans, and I reject inflation protection."

[Statutory Authority: RCW 48.02.060, 48.84.030, 48.01.030. 94-14-100 (Order R 94-10), § 284-54-270, filed 7/6/94, effective 8/6/94.]

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 preexisting 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.

Long-Term Care Insurance Rules

284-54-350

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? _____	Are conditions for which you have been created: -excluded? _____ -limited? _____	Yes/No If yes, Explain: _____	Amount of co-payment charge: _____
- after you become ill: _____	Treatment how long ago? _____	_____	Deductible: _____
Other significant exclusions: _____	Excluded how long? _____	_____	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? _____ Chore Services? _____ Meals/Nutritional Services? _____ Respite Care? _____ Adult Day Care? _____ Durable Medical Equipment? _____	Transportation? _____ Physician/Nursing Services? _____ Therapists? _____ Medical/Social Worker Services? _____ Drugs? _____ Other: _____ _____	Prior in-patient care required? Yes/No _____ Prior level of in-patient care required? _____ Assessment by case manager or other required? Yes/No _____ Explain: _____ _____
		Maximum number of days or visits: _____ Maximum duration of visits: _____ Dollar Maximum: _____ _____

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 SUPPLEMENT INSURANCE REGULATION

(Substantially superseded by chapter 284-66 WAC)

WAC

284-55-010
284-55-020

Limited purpose of this chapter.
Applicability and scope.

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284-55-040	Prohibited policy provisions.
284-55-045	Minimum benefit standards.
284-55-050	Outline of coverage required.
284-55-060	Form for "outline of coverage."
284-55-065	Buyer's guide.
284-55-067	Notice regarding policies or subscriber contracts which are not Medicare supplement policies.
284-55-070	Requirements for application forms, replacement.
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284-55-120	Attained age rating prohibited.
284-55-125	Riders and endorsements.
284-55-150	Filing requirements and premium adjustments.
284-55-155	Filing requirements for out-of-state group policies.
284-55-160	Annual adjustment notice to conform existing Medicare supplement policies to Medicare changes.
284-55-165	Form of annual adjustment notice—Policy changes effective January 1, 1989.
284-55-180	Requirements for advertising.
284-55-185	Compliance with Omnibus Budget Reconciliation Act of 1987.
284-55-190	Chapter not exclusive.
284-55-205	Medicare supplement loss ratio experience form required.
284-55-210	Form of Medicare supplement loss ratio experience.

7), § 284-55-177, filed 5/24/89.] Repealed by 90-17-038 (Order R 90-7), filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 and 48.66.041.

WAC 284-55-010 Limited purpose of this chapter.

(1) Regulation of Medicare supplemental insurance policies under chapter 284-55 WAC is limited to those guaranteed renewable policies which were delivered to residents of this state prior to January 1, 1989. Such guaranteed renewable policies shall also be subject to the requirements of chapter 284-66 WAC as provided at WAC 284-66-020 (2)(a). All Medicare supplemental insurance policies delivered to residents of this state after December 31, 1988, are regulated by the provisions of chapter 284-66 WAC, adopted March 16, 1990. Policies that are not guaranteed renewable and which were delivered to residents of this state prior to January 1, 1990, are also subject to the provisions of chapter 284-66 WAC.

(2) 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 program benefits.

[Statutory Authority: RCW 48.02.060 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-010, filed 8/10/90, effective 9/10/90. 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.]

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).
284-55-130	Substitution of policies. [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.] Repealed by 89-20-017 (Order R 89-11), filed 9/27/89, effective 10/28/89. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200 and 48.66.041.
284-55-170	Form of annual adjustment notice—Policy changes effective January 1, 1990. [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.] Repealed by 89-11-096 (Order R 89-7), filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050.
284-55-172	Form of annual adjustment notice—Policy changes effective January 1, 1990. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-172, filed 5/24/89.] Repealed by 90-17-038 (Order R 90-7), filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 and 48.66.041.
284-55-175	Form of annual adjustment notice—Policy changes effective January 1, 1991. [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.] Repealed by 89-11-096 (Order R 89-7), filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050.
284-55-177	Form of annual adjustment notice—Policy changes effective January 1, 1991. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-

WAC 284-55-020 Applicability and scope. (1) This chapter applies to guaranteed renewable Medicare supplemental insurance policies delivered to residents of this state prior to January 1, 1989, including every such group and individual policy of disability insurance and to every such 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 chapter 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 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-020, filed 8/10/90, effective 9/10/90. 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.

(5) "Guaranteed renewable" means a Medicare supplemental insurance policy or certificate which is renewable solely at the option of the insured by the timely payment of premiums, except that the insurer may make changes in premium rates by classes.

[Statutory Authority: RCW 48.02.060 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-030, filed 8/10/90, effective 9/10/90. 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.

(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-035, filed 5/24/89. 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. The form of outline shall be filed with the commissioner prior to use in this state.

(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-050, filed 5/24/89. 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:)

	THIS	
	POLICY	YOU
SERVICE	PAYS	PAY

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

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 chart shall accompany the outline of coverage and the form thereof shall be filed with the commissioner prior to use in this state:)

Part A
 MEDICARE BENEFITS IN

Service	1988	1989	1990	1991
PART A				
Inpatient Hospital Services:	All but \$540 for first 60 days/benefit period	All but \$560 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 day/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) per benefit period			

Skilled Nursing Facility Care	100% of costs for first 20 days (after 3-day prior hospital confinement)	80% of Medicare reasonable costs for first 8 days per calendar year without prior hospitalization requirement	80% for 1st 8 days/calendar year	80% for 1st 8 days/calendar year
	All but \$67.50 a day for 21st - 100th days			
	Nothing beyond 100 days	100% of costs thereafter up to 150 days/calendar year	100% for 9th-150th day/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> .	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)
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Part A blood deductible reduced to the extent paid under Part B.

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Part B
 MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
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Parts A & B:

Home Health Services	Intermittent skilled nursing home 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 1988 and 1989)		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 1990 & 1991)	
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PART B

Medical Expense: Services of a Physician/Out-patient Services -- Medical Supplies Other than Prescribed Drugs	80% of reasonable charges after an annual \$75 deductible	80% after \$75 deductible	80% of reasonable charges after \$75 deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for the remainder of the calendar year. (same 1990 and 1991)	
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Blood	80% of costs except non-replacement fees (blood deductible) for 1st 3 pints in <u>each benefit period</u> 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 1989, 1990 and 1991)		
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Mammography Screening		80% of approved charge for elderly and disabled Medicare beneficiaries -- exams available every other year for women age 65 and older (same 1990 and 1991)		
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Out-of-Pocket Maximum		\$1,370 consisting of Part B \$75 deductible, PartB blood deductible and 20% co-insurance (same 1990 & 1991, except \$1,370 will be adjusted annually by Sec. Health & Human Services)		
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Part B
 MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Outpatient Prescription Drugs			There is a \$550 total deductible for home IV drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% co-insurance

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 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 benefit 1988 and 1989)		Same as 1988 & 1989 for 1st year following covered transplant; then 50% of costs during 2nd and following years (subject to \$550 deductible in 1990, \$600 in 1991)	
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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 in 1990 and 1991)	
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(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-060, filed 5/24/89. 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. The form shall be filed with the commissioner prior to use in this state.

(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-070, filed 5/24/89. 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 preexisting conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning

your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

.....
(Date)

.....
(Applicant's Signature)

[Statutory Authority: RCW 48.02.060 (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 284-55-115 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, policy reserves, and claim reserves and liabilities, both nationally and for this state. The form for filing this information is provided at WAC 284-55-205 through 284-55-210.

(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 loss ratio for the third policy year, greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years. The applicable percentage shall be as defined in subsection (6), (7), or (8) of this section.

(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-115, filed 5/24/89. 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 284-55-150 Filing requirements and premium adjustments. (1) For Medicare supplement insurance policies 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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-150, filed 5/24/89. 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 284-55-177. 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. The forms

of annual adjustment notices provided to residents of this state shall be filed with the commissioner prior to use.

(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 48.66.050. 89-11-096 (Order R 89-7), § 284-55-160, filed 5/24/89. 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

	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
Medicare Now Pays Per Benefit Period			

MEDICARE PART A: SERVICES AND SUPPLIES

First 60 days - all but \$540 Unlimited number of hospital days after \$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
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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).

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.]

WAC 284-55-205 Medicare supplement loss ratio experience form required. The form provided at WAC 284-55-210 shall be filed with the commissioner annually not later than June 30th of each calendar year beginning June 30, 1990. The form is to be filed in addition to the NAIC experience exhibit and not in lieu thereof.

The following instructions must be followed when completing the form:

(1) The data shall be furnished in the same format and order as that shown at WAC 284-55-210;

(2) The name of the insurer must be clearly shown at the top of each page;

(3) Separate data must be shown for each policy form number and for each policy duration of each form;

(4) The current approved rate schedule for each policy form number shall be attached to the experience form and shall show the policy form number for purposes of identification;

(5) Incurred losses shall include claims paid and the change in claim reserves and liabilities. A list of items that are not to be included in incurred losses is provided at WAC 284-55-115(4);

(6) The loss ratio shall be the ratio of incurred losses to earned premium;

(7) The experience form shall be certified by an officer of the insurer;

(8) Complete data is required for each policy form on both a national basis and for policies sold in the state of Washington;

(9) Policy reserves shall include:

(a) Active life reserves;

(b) Contingency and additional reserves;

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

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-205, filed 5/24/89.]

WAC 284-55-210 Form of Medicare supplement loss ratio experience. The following form of Medicare supplement loss ratio experience shall be used by all insurers:

MEDICARE SUPPLEMENT LOSS RATIO EXPERIENCE
(SUMMARIZED BY POLICY YEAR)

Experience reported for January 1 to December 31 of 19_____

To be filed on or before June 30

of the _____

Address (City, State, and Zip Code) _____

NAIC Group Code _____ NAIC Company Code _____ CIC Code _____

National Experience

<u>Form No.</u>	<u>No. of Contracts in Force</u>	<u>Policy Duration</u>	<u>Incurred Losses</u>	<u>Earned Premiums</u>	<u>Loss Ratio</u>	<u>Unearned Premium Reserve</u>	<u>Policy Reserves</u>	<u>Claim Reserves</u>
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Washington Experience

<u>Form No.</u>	<u>No. of Contracts in Force</u>	<u>Policy Duration</u>	<u>Incurred Losses</u>	<u>Earned Premiums</u>	<u>Loss Ratio</u>	<u>Unearned Premium Reserve</u>	<u>Policy Reserves</u>	<u>Claim Reserves</u>
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I hereby certify that I have supervised the preparation of this experience exhibit, that it is complete and accurate to the best of my knowledge, and it is in compliance with RCW 48-66-150, WAC 284-55-115 and WAC 284-55-150.

Signature of Officer

Date

Name and Title of Officer

Prepared by

Phone Number

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-210, filed 5/24/89.]

Chapter 284-58 WAC

REGULATIONS PERTAINING TO FORM FILINGS

WAC

284-58-010	Title and purpose.	284-58-120	Blanket disability insurance forms which may be filed by certification.
284-58-020	Scope and general contents.	284-58-130	Individual life insurance and annuity forms, certification not permitted.
284-58-030	General contents of all life and disability form and disability rate filings.	284-58-140	Individual life insurance and annuity forms which may be filed by certification.
284-58-040	Life and disability filing report documents.	284-58-150	Group life insurance and annuity contract forms, certification not permitted.
284-58-050	Document to be used in filing life and disability forms.	284-58-160	Group life insurance and annuity forms which may be filed by certification.
284-58-060	Document to be used in filing disability rates.	284-58-170	Credit insurance forms, certification not permitted.
284-58-070	General designation of life and disability forms which may not be filed by certification.	284-58-180	Fraternal benefit society forms.
284-58-080	Individual disability insurance forms, certification not permitted.	284-58-190	Certification form to be used for disability insurance form filings.
284-58-090	Group disability insurance forms, certification not permitted.	284-58-200	Form to be used for certification of disability insurance form or rate filings.
284-58-100	Group disability insurance forms which may be filed by certification.	284-58-210	Certification form to be used for life insurance and annuity form filings.
284-58-110	Blanket disability insurance forms, certification not permitted.	284-58-220	Form to be used for certification of life insurance or annuity form filings.
		284-58-250	General contents of a form filing for property and casualty insurance and kinds of insurance other than life and disability.

- 284-58-260 Designation of forms for insurances other than life and disability which may not be filed by certification.
- 284-58-270 Certification form to be used for property and casualty insurance.
- 284-58-280 Form to be used for certification of property or casualty insurance form filings.

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

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

(3) The fees for filing both forms and rates, and the definitions of such filings for purposes of determining the proper filing fees, are set forth in WAC 284-14-010.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-010, filed 11/5/82.]

WAC 284-58-020 Scope and general contents. (1) This regulation applies to all insurers and to all forms required to be filed with the commissioner pursuant to RCW 48.18.100, and to all manuals of classification, manuals of rules and rates and modifications thereof required to be filed with respect to disability insurance pursuant to RCW 48.19.010(2).

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

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

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

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

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

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

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

(f) The form to be used for the certification of forms for insurances other than life and disability is set forth in WAC 284-58-280.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-020, filed 11/5/82.]

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

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

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

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

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

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

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

(7) Any additional required enclosure.

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

WAC 284-58-040 Life and disability filing report documents. Filing report documents have been established to facilitate and expedite the forms review process with respect to life and disability insurance and must be used with every form filing. A cover letter will not be necessary except with respect to an exceptional filing. The filing report document to be used for life and disability form filings is set forth in WAC 284-58-050. The filing report document to be used for disability insurance rates is set forth in WAC 284-58-060.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-040, filed 11/5/82.]

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

STATE OF WASHINGTON

FILING REPORT - LIFE AND DISABILITY FORMS

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

1. Company Name:
2. Date of Submission:
3. Company Mailing Address:
4. Check if the form(s) will be used for Blanket (), Franchise (), or Mass-marketing purposes ().

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

6. Type of Filing:
- | Form or Group of Similar Forms* | Form # | Forms to be replaced. Give form numbers |
|--------------------------------------|--------|---|
| <input type="checkbox"/> Policy | | |
| <input type="checkbox"/> Application | | |
| <input type="checkbox"/> Rider | | |
| <input type="checkbox"/> Endorsement | | |
| <input type="checkbox"/> Amendment | | |
| <input type="checkbox"/> Other | | |

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

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

- 8. What line of insurance is involved?
 - Group
 - Blanket
 - Individual
 - Franchise
 - Mass Marketed Individual Forms
 - Other, please explain in a cover letter

- 9. If an individual policy form is being filed, what type of product is involved?
 - Universal Life
 - Indeterminate Premium Life
 - Adjustable - Optional Increases in Face
 - Fixed Benefit, Fixed Level Premium Life
 - Graded Benefit or Graded Premium Life
 - Deposit Term or Deposit Permanent
 - Reentry Term
 - Reversion Privilege Term
 - Retired Lives Reserve
 - Flexible Premium Annuity
 - Savings Annuity
 - Reversionary Annuity
 - Fixed Premium Annuity
 - Accident Only
 - Health
 - Monthly Income Disability
 - Medicare Supplement
 - Credit
 - Separate Account Insurance Forms
 - Other, please explain in a cover letter

- 10. Check here if there are any unusual features or provisions in this filing. Examples include variable premiums and coverages, limited markets or unusual underwriting. If checked, explain fully in a cover letter.

- 11. Check here if this filing contains any provisions previously disapproved by this office. If checked, describe fully in a cover letter.

- 12. List other health insurance forms of the same generic type presently marketed. If such other forms are of nearly identical benefits, explain the need for this form in a cover letter.

- 13. Check here if the form is filed as a result of a change in a Washington statute or regulation. Please give citation:

- 14. Check here if the forms filed are substantially identical to other forms recently approved in Washington. State the form numbers and indicate the provisions which differ. . . . , , , ,

- 15. Check here if this form is to be issued to a trust. (The certificate issued to the participant must be filed.)

- 16.
Signature of designated representative with whom this submission may be discussed
.....
Name printed or typed with title
.....
Telephone number
.....

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

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

STATE OF WASHINGTON
FILING REPORT - DISABILITY RATES

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

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

6. Type of Filing: Rates to be used with insurance form or group of similar forms*
- () Initial Filing of Rates
 - () Rate Increase/Decrease
 - () Automatic Medicare Rate Increase
 - () Rate Deviation Credit Insurance
 - () Other

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

7. This filing is made for () Approval by the Commissioner or () As a Certified Filing — Certificate attached
8. Date(s) of Domiciliary Form(s) and Rate Approval(s):
9. Give the approval date of the form(s) and the effective date(s) of any rate increase(s) in the state of Washington.
Form Numbers:
Previous rate increases
10. What is the scope and reason for the rate increase? (Enclose actuarial justification and demonstration.)
11. Does the filing apply to: () new business, () to in force business, () both? State reasons therefor.
12. To what degree is it anticipated that this rate increase will result in additional lapses and worsened morbidity experience.
13. () Check here if there are any unusual features or provisions to this filing requiring special rate considerations. If checked, explain fully in a cover letter.
14. () Check here if this filing contains any rates previously disapproved by this Office. If checked, describe fully in a cover letter.
15. List other health insurance forms of the same generic type presently marketed. Explain in a cover letter if such forms were grouped together with form(s) of this filing for pricing or experience study purposes, but are now kept separate.
16. () Check here if the rates are filed as a result of a change in a Washington statute or regulation concerning policy benefits or rate structure. Please give the citation:
17. () Check here if the rates filed are for forms similar to other forms recently approved in Washington.

Please list the form numbers:

18.
Signature of designated representative with whom this filing may be discussed
.
Name printed or typed with title
.
Telephone number

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

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

- (1) Forms of a type not previously reviewed and approved in the state of Washington for the particular filing company, as, for example, when a company enters a new segment of the insurance market such as a life insurer first entering the group or credit insurance market.
- (2) Any form containing unusual features or provisions. Examples include variable premiums and coverages, limited markets or unusual underwriting.
- (3) Any form containing any provision previously disapproved by this state.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-070, filed 11/5/82.]

WAC 284-58-080 Individual disability insurance forms, certification not permitted. No individual disability insurance forms may be filed by the certification process. All must be filed for approval.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-080, filed 11/5/82.]

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

- (1) Medicare supplement insurance forms.
- (2) Forms to be used with association groups as defined in RCW 48.24.045.
- (3) Forms to be used with debtor groups as defined in RCW 48.24.040.
- (4) Excess risk or loss insurance.
- (5) Any other form not listed in WAC 284-58-100.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-090, filed 11/5/82.]

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

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

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

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

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

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

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

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

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

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

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

(11) Manuals of classification, manuals of rules and rates, and any modifications thereof filed pursuant to RCW 48.19.010(2).

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-100, filed 11/5/82.]

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

(1) Forms submitted under RCW 48.21.040 (1)(f).

(2) Any other form not listed in WAC 284-58-120.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-110, filed 11/5/82.]

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

(1) Forms to be used with common carrier groups, volunteer organizations, nonprofit welfare organizations, exceptional work hazards employees, and student and faculty groups, as defined in RCW 48.21.040 (1)(a) through (e).

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

(3) Manuals of classification, manuals of rules and rates, and any modifications thereof filed pursuant to RCW 48.19.010(2).

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-120, filed 11/5/82.]

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

(1) Variable insurance forms used with a separate account.

(2) Universal life forms.

(3) Indeterminate premium forms.

(4) Lower premiums for nonsmokers and other groups of better risks when such premiums are not guaranteed for the full premium paying period.

(5) Refiling of cash values pursuant to section 14(4)(j), chapter 9, Laws of 1982 1st ex. sess.

(6) Deposit term insurance forms.

(7) Deposit permanent insurance forms.

(8) Retired lives reserves.

(9) Reentry term.

(10) Graded premium forms.

(11) Modified benefit forms.

(12) Flexible premium or single premium annuity with excess interest or similar provisions.

(13) Savings annuity.

(14) Reversionary annuity.

(15) Any annuity policy or rider form with a policy loan provision.

(16) All charitable annuity forms.

(17) All funeral insurance forms.

(18) All coupon policy forms.

(19) All industrial insurance forms.

(20) Accidental death benefit riders.

(21) Waiver of premium disability riders.

(22) Any other form not listed in WAC 284-58-140.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-130, filed 11/5/82.]

WAC 284-58-140 Individual life insurance and annuity forms which may be filed by certification.

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

(1) Level benefit, level premium, limited pay or single premium whole life contracts.

(2) Level benefit, level premium, limited pay single premium joint whole life contracts.

(3) Level premium endowment forms which endow for the face amount.

(4) Single premium endowment forms which endow for the face amount.

(5) Retirement income, income endowment, or life income to age 65 or other retirement age.

(6) Family plans consisting of level premium, level benefit term or permanent insurance.

(7) Level premium, level benefit term insurance whether renewable or convertible or not.

(8) Level premium decreasing term insurance with or without nonforfeiture values.

(9) Fixed premium or single premium deferred or immediate annuities.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-140, filed 11/5/82.]

WAC 284-58-150 Group life insurance and annuity contract forms, certification not permitted.

The following types of group life insurance and group annuity forms may not be filed by the certification process, but must be filed for approval:

(1) Variable insurance forms used with a separate account.

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

(3) Forms to be used with association groups as defined in RCW 48.24.045.

- (4) Excess risk or loss insurance.
- (5) Any other form not listed in WAC 284-58-160.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-150, filed 11/5/82.]

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

- (1) Forms to be used with employee groups as defined in RCW 48.24.020.
- (2) Forms to be used with dependent groups as defined in RCW 48.24.030.
- (3) Forms to be used with credit union groups as defined in RCW 48.24.035.
- (4) Forms to be used with labor union groups as defined in RCW 48.24.050.
- (5) Forms to be used with public employee association groups as defined in RCW 48.24.060.
- (6) Forms to be used with trustee groups as defined in RCW 48.24.070.
- (7) Forms to be used with agent groups as defined in RCW 48.24.080.
- (8) Forms to be used with financial institution groups as defined in RCW 48.24.095.
- (9) Forms to be used with qualified pension plans.
- (10) Forms to be used with nonqualified pension plans.
- (11) Forms to be used with a one case filing.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-160, filed 11/5/82.]

WAC 284-58-170 Credit insurance forms, certification not permitted. No credit insurance forms may be filed by the certification process. All must be filed for approval.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-170, filed 11/5/82.]

WAC 284-58-180 Fraternal benefit society forms. All fraternal benefit society forms may be filed by the certification process.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-180, filed 11/5/82.]

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

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-190, filed 11/5/82.]

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

STATE OF WASHINGTON
CERTIFICATION

DISABILITY INSURANCE FORM(S) AND RATE FILING

Company Name:

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

I hereby certify that to the best of my knowledge and judgment this form and rate filing is in compliance with the applicable laws and regulations of the state of Washington, that the benefits are reasonable in relation to the premiums, that formulas for loading and contingency margins are applied consistently and equitably to all the forms, benefits, issue ages, years of issue and other classifications employed including successive generic forms and generations of policyholders, that the calculations were based on my best estimate of the future experience including the need for contingency reserves and that the future experience has been projected only within a time period over which the premiums may reasonably be expected to remain adequate. The manual rates and classifications are attached, as are loss ratio calculations for groups to which the manual rates will apply. I certify that to the best of my knowledge the form does not contain or incorporate by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

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

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

.....
Date:
Telephone No.

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

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

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-210, filed 11/5/82.]

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-250, filed 11/5/82.]

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

STATE OF WASHINGTON
CERTIFICATION
LIFE INSURANCE AND ANNUITY FORM FILINGS

Company Name:

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

I have prepared or supervised the preparation of the actuarial formula for this policy. The actuarial demonstrations are attached. I certify that the nonforfeiture benefits for this form, for every age and face amount combination are in compliance with the applicable laws and regulations of the state of Washington. I certify that to the best of my knowledge and judgment, this form is in compliance with the applicable laws and regulations of the state of Washington, and the form does not contain or incorporate any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract and that all of the conditions pertaining to the insurance are explicitly stated in the contract.

(Signature)

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

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

.....
Date:
Telephone No.

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

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

- (1) A completed filing transmittal information form as prescribed in WAC 284-14-020. (If the form being filed is a revision or replacement of an existing form, include or attach a summary of the change being made.)
- (2) If applicable, a completed certification form as prescribed in WAC 284-58-270.
- (3) The printed form or forms, in duplicate.
- (4) The appropriate filing fee as prescribed by WAC 284-14-010.

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

- (a) Fire and allied lines;
- (b) Farmowners multiple peril;
- (c) Homeowners multiple peril;
- (d) Commercial multiple peril;
- (e) Inland marine;
- (f) Professional liability;
- (g) Earthquake;
- (h) Private passenger automobile;
- (i) Commercial automobile;
- (j) General liability;
- (k) Glass;
- (l) Crime coverage;
- (m) Boiler and machinery; and
- (n) Credit.

(2) Whenever a policy form or endorsement identified in subsection (1) of this section has been filed by a rating organization with, and approved by, the commissioner, a form with identical substantive wording may be filed by an individual insurance company by the certification process.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-260, filed 11/5/82.]

WAC 284-58-270 Certification form to be used for property and casualty insurance. If an insurer elects to file a property or casualty insurance form, or a form for a kind of insurance other than life and disability, through the certification process, as permitted by this chapter, it shall complete a certification form, the contents of which shall be as set forth in WAC 284-58-280, and submit such certification form, together with the other contents required by WAC 284-58-250, to the commissioner.

[Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-270, filed 11/5/82.]

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

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

To the Washington State Insurance Commissioner

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

(Type or print company's name:)

(Signature)

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

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

Date:
Telephone No.

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

Chapter 284-60 WAC
DISABILITY INSURANCE LOSS RATIOS

WAC

Table with 2 columns: WAC number and description. Includes 284-60-010 Scope, 284-60-020 Purpose, 284-60-030 Definitions, 284-60-040 Grouping of policy forms, 284-60-050 Loss ratio requirements, 284-60-060 Loss ratio requirement for group and blanket disability insurance policy forms, 284-60-070 Experience records, 284-60-080 Evaluating experience data, 284-60-090 Special circumstances, 284-60-100 Effective date.

WAC 284-60-010 Scope. (1) This regulation, WAC 284-60-010 through 284-60-100, applies to all insurers and to every disability insurance policy form filed for approval in this state after August 31, 1983, except:

- (a) Additional indemnity and premium waiver forms for use only in conjunction with life insurance policies;
(b) Medicare supplement policy forms which are regulated by chapter 284-55 WAC;
(c) Credit insurance policy forms issued pursuant to chapter 48.34 RCW;
(d) Group policy forms other than:
(i) Specified disease policy forms,
(ii) Policy forms, other than loss of income forms, as to which all or substantially all, of the premium is paid by the individuals insured thereunder,
(iii) Policy forms, other than loss of income forms, for issue to single employers insuring less than one hundred employees;
(e) Policy forms filed by health care service contractors or health maintenance organizations;
(f) Policy forms initially approved before September 1, 1983, including subsequent requests for rate increases and modifications of rate manuals.

(2) Approvals of policy forms of the types subject to this regulation approved before September 1, 1983, and which are not in compliance with the provisions of this regulation on January 1, 1985, are hereby withdrawn as of January 1, 1985, and such forms shall not thereafter be used for new issues.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-010, filed 6/23/83, effective 9/1/83.]

WAC 284-60-020 Purpose. The purpose of this regulation is to:

(1) Establish loss ratio standards for the purpose of implementing the authority of the commissioner to disapprove and to withdraw approval of disability policy forms which are not returning or are not expected to return a reasonable proportion of the premiums in the form of benefits, pursuant to RCW 48.18.110(2), 48.19.010(2), 48.70.030 and 48.70.040.

(2) Define certain practices in the use of policy forms and in the making of disability insurance rates to be unfair, deceptive and discriminatory practices, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-020, filed 6/23/83, effective 9/1/83.]

WAC 284-60-030 Definitions. (1) 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 actuary's best projections of the future experience within the "calculating period."

(2) 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.

(3) 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.

(4) The "calculating period" shall be the time span over which the 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 actuary does not expect to request a rate increase.

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

(6) 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.

(7) The "reserves," as referred to in this regulation, 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.

(8) 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.

(9) Renewal provisions are defined as follows:

(a) "Guaranteed renewable"—Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

(b) "Noncancellable"—Renewal cannot be declined nor can rates be revised by the insurance company.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-030, filed 6/23/83, effective 9/1/83.]

WAC 284-60-040 Grouping of policy forms for purposes of rate making and requests for rate increase.

(1) The actuary responsible for setting premium rates shall group similar policy forms, including forms no longer being marketed, 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 policyholders. Such grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.18.480.

(2) The insureds under similar policy forms are grouped at the time of rate making in accord with RCW 48.18.480 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 and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to withdraw a form from its assigned grouping by reason only of the deteriorating health of the people insured thereunder.

(3) One or more of the policy 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 and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to deviate from the assigned grouping of policy forms for pricing purposes at the time of requesting a rate increase unless the 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 policy forms of similar benefits are sometimes introduced by the insurers 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, policyholders who can not qualify for the new improved policies, or to whom the new benefits are not offered, are left insured and 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 and discriminatory practice, pursuant to RCW 48.01.030, 48.18.480 and 48.30.010, to fail to combine successive generic policy forms and to fail to combine policy forms of similar benefits covering generations of policyholders in the calculation of premium rates and loss ratios.

[Statutory Authority: RCW 48.02.060, 83-14-002 (Order R 83-1), § 284-60-040, filed 6/23/83, effective 9/1/83.]

WAC 284-60-050 Loss ratio requirements for individual disability insurance forms. The following standards and requirements apply to individual disability insurance 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 insurer and satisfactory to the commissioner.

(2) The calculating period may vary with the benefit and renewal provisions. The company 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) Policy 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. Policy 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 policy 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 coverages, inside benefit limits, or the inherent nature of the benefits. The calculating period may be as short as one year for coverages 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 calculating 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 approve a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and anti-selection 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) Companies 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, 83-14-002 (Order R 83-1), § 284-60-050, filed 6/23/83, effective 9/1/83.]

WAC 284-60-060 Loss ratio requirement for group and blanket disability insurance policy forms and manual rates. The following standards and requirements apply to group and blanket disability insurance policy forms and manual rates:

(1) Specified disease group insurance shall generate at least a seventy-five percent loss ratio regardless of the size of the group.

(2) Group disability insurance, other than specified disease insurance, as to which the insureds pay all or substantially all of the premium shall generate loss ratios no lower than those set forth in the following table.

Number of Certificate Holders at Issue, Renewal or Rerating	Minimum Overall Loss Ratio
9 or less	60%
10 to 24	65%
25 to 49	70%
50 to 99	75%
100 or more	80%

(3) Group disability policy forms, other than for specified disease insurance, for issue to single employers insuring less than one hundred lives shall generate loss ratios no lower than those set forth in subsection (2) of this section for groups of the same size.

(4) The calculating period may vary with the benefit and premium provisions. The company may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations.

(5) A request for a rate increase submitted at the end of the calculating period shall include a comparison of the actual to the expected loss ratios and shall employ any accumulation of reserves in the determination of rates for the selected calculating period and 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.

(6) A request for a rate increase submitted during the calculating period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to or 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.

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

(8) Companies 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. 83-14-002 (Order R 83-1), § 284-60-060, filed 6/23/83, effective 9/1/83.]

WAC 284-60-070 Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each policy year for each policy, rider, endorsement 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 policy year experience based on calendar year data.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-070, filed 6/23/83, effective 9/1/83.]

WAC 284-60-080 Evaluating 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, economic cycles affecting disability income experience, inflation in expense charges and others;

(3) The concentration of experience at early policy 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 policy 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. 83-14-002 (Order R 83-1), § 284-60-080, filed 6/23/83, effective 9/1/83.]

WAC 284-60-090 Special circumstances. Loss ratios other than those indicated in WAC 284-60-050 and 284-60-060 may be approved with satisfactory actuarial demonstrations. Examples of coverages where the commissioner may grant special considerations are:

(1) Short term nonrenewable policy forms such as airline trip or student accident.

(2) Policy forms exposed to high risk of claim fluctuation because of the low loss frequency, or the catastrophic or experimental nature of the coverage.

(3) Individual guaranteed renewable and noncancellable policy forms, but the loss ratio shall not be less than those set forth in the following table in lieu of those specified in WAC 284-60-050. In the calculation of loss ratios for such policies the reserves, except those required by RCW 48.12.030 (3)(a), shall be excluded from consideration as benefits incurred.

	Guaranteed Renewable	Noncancellable
Medical Expense	55%	50%
Loss of Income and Other	50%	45%

(4) Cases where higher than usual expenses are expected because of peculiar administrative or geographic circumstances.

(5) Freestanding group or blanket contracts for benefits which are normally written in conjunction with other benefits.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-090, filed 6/23/83, effective 9/1/83.]

WAC 284-60-100 Effective date. This regulation shall become effective on September 1, 1983, and shall apply to all policy, rider, endorsement, and similar forms and rate schedule filings subject to this regulation submitted on or after said date.

[Statutory Authority: RCW 48.02.060. 83-14-002 (Order R 83-1), § 284-60-100, filed 6/23/83, effective 9/1/83.]

**Chapter 284-66 WAC
WASHINGTON MEDICARE SUPPLEMENT
INSURANCE REGULATION**

WAC

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- 284-66-323 Form for reporting multiple Medicare supplement policies and certificates.
- 284-66-330 Standards for marketing.
- 284-66-340 Appropriateness of recommended purchase and excessive insurance.
- 284-66-350 Permitted compensation arrangements.
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**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 284-66-070 Reserved. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-070, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-090 Form for "outline of coverage." [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-090, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-100 Form for 1990 adjustment notice to accompany outline of coverage. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-100, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-140 Form for "replacement notice to applicant" for other than direct response insurers. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-140, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-150 Form for "replacement notice to applicant" by direct response insurers. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-150, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-180 Continuous renewability required. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-180, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.
- 284-66-190 Offer of reinstatement of coverage. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-190, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order R 92-

1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.

284-66-230

Form for reporting Medicare supplement loss ratio experience. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-230, filed 3/20/90, effective 4/20/90.] Repealed by 92-06-021 (Order 92-1), filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200.

WAC 284-66-010 Purpose. The purpose of this chapter is to effectuate the provisions of RCW 48.20.450, 48.20.460 and 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, and to supplement the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act; 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 simplification and standardization of the coverage, terms, and benefits of Medicare supplement insurance policies and certificates, and to eliminate policy provisions which may duplicate Medicare benefits as the federal Medicare program changes; to facilitate public understanding and comparison of such policies and to eliminate provisions contained in such policies which may be misleading or confusing; to establish minimum standards for Medicare supplement insurance, an "outline of coverage" and other disclosure requirements; to prohibit the use of certain provisions in Medicare supplemental insurance policies; to define and prohibit certain acts and practices as unfair methods of competition or unfair or deceptive acts or practices; and to establish loss ratio requirements, policy reserves, filing and reporting procedures.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-010, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-010, filed 3/20/90, effective 4/20/90.]

WAC 284-66-020 Applicability and scope. (1) Subject to subsection (2) of this section, except as provided by federal law, chapter 48.66 RCW, or as otherwise specifically provided by this chapter, this chapter shall apply to every group and individual policy of disability insurance and to every subscriber contract of an issuer (other than a policy issued pursuant to a contract under section 1876 or section 1833 of the Social Security Act [42 U.S.C. section 1395 et seq.] or an issued policy under a demonstration project authorized pursuant to amendments to the Social Security Act), 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. All such policies or contracts are referred to in this chapter as

"Medicare supplemental insurance" or "Medicare supplement insurance policy" or "Medicare supplement coverage."

(2)(a) Medicare supplement insurance policies delivered prior to January 1, 1989, which are renewable solely at the option of the insured by the timely payment of premium shall be subject to the provisions of this chapter except with respect to WAC 284-66-060, 284-66-200, 284-66-210, 284-66-310, and 284-66-350. To the extent that the provisions of this chapter do not apply to such policies, chapter 284-55 WAC shall apply.

(b) Medicare supplement insurance policies delivered between January 1, 1989, and December 31, 1989, and which are renewable solely at the option of the insured by the timely payment of premium shall be governed by this chapter except with respect to the requirements of WAC 284-66-210 and 284-66-350.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-020, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-020, filed 3/20/90, effective 4/20/90.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-030 Definitions. For purposes of this chapter:

(1) "Applicant" means:

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

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

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy regardless of the situs of the group master policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, and any other entity delivering or issuing for delivery Medicare supplement policies or certificates.

(5) "Direct response issuer" means an issuer 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.

(6) "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance appertaining thereto. For purposes of this chapter, disability insurance shall include policies or contracts offered by any issuer.

(7) "Health care expense costs" means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services which expenses 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.

(8) "Policy" includes agreements or contracts issued by any issuer.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(10) "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 issuer in consideration for such policy is deemed part of the premium. "Earned premium" shall mean the "premium" applicable to an accounting period whether received before, during or after such period.

(11) "Replacement" means any transaction in which new Medicare supplement coverage is to be purchased, and it is known or should be known to the proposing agent or other representative of the issuer, or to the proposing issuer if there is no agent, that by reason of such transaction, existing Medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-030, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-030, filed 3/20/90, effective 4/20/90.]

WAC 284-66-040 Policy definitions and terms. No policy or certificate may be advertised, solicited, issued for delivery in this state after July 1, 1992, as a Medicare supplement insurance policy or certificate unless such policy or certificate 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 or 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, or motor vehicle no-fault plan, unless prohibited by law.

(2) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(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, but not more restrictively than as defined in the Medicare program.

(4) "Medicare" shall be defined in the policy and certificate. Medicare may be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later

amended" or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(5) "Physician" shall not be defined more restrictively than as defined in the Medicare program.

(6) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness 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, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-040, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-040, filed 3/20/90, effective 4/20/90.]

WAC 284-66-050 Policy provisions. (1) No policy may be advertised, solicited, or issued for delivery in this state as a Medicare supplement insurance policy unless such policy meets or exceeds the requirements for such policies imposed by chapter 48.66 RCW.

(2) No Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(3) Except for permitted preexisting condition clauses as described in WAC 284-66-063 (1)(a) no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(4) The terms "Medicare supplement," "Medicare wrap-around," "Medigap," or words of similar import shall not be used to describe an insurance policy unless such policy is issued in compliance with chapter 48.66 RCW and this chapter.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-050, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-050, filed 3/20/90, effective 4/20/90.]

WAC 284-66-060 Minimum benefit standards. The requirements of this section apply to Medicare supplement policies and certificates issued or issued for delivery in this state during the period beginning January 1, 1990, and ending June 30, 1992, as well as all guaranteed renewable Medicare supplement policies delivered to residents of this state during 1989 and which were conformed to meet the minimum benefit standards of this section pursuant to the Medicare Catastrophic Coverage Act. Minimum standards for "standardized" policies and certificates are provided at WAC 284-66-063. Effective July 1, 1992, only policies

meeting the standards of WAC 284-66-063 may be advertised, solicited, or issued for delivery in this state. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

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

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

(5) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

(7) 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), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-060, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-060, filed 3/20/90, effective 4/20/90.]

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered on or after July 1, 1992.

Only Medicare supplement policies or certificates meeting the requirements of this chapter may be delivered or issued for delivery in this state on or after July 1, 1992. After that date, no policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or

treatment was recommended by or received from a physician within six months before the effective date of coverage.

(b) No Medicare supplement policy or certificate shall 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.

(c) Each Medicare supplement policy shall be guaranteed renewable and:

(i) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for such benefits as otherwise meets the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate 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 conditioned 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.

(e)(i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(ii) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated

(effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(iii) Reinstitution of such coverages;

(A) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(B) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(C) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to all benefit plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof.

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

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packaged red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits shall be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (i)(ii) of this subsection and patient education to address preventive health care measures.

(ii) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Fecal occult blood test and/or digital rectal examination;

(B) Mammogram;

(C) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(D) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(E) Serum cholesterol screening (every five years);

(F) Thyroid function test;

(G) Diabetes screening.

(iii) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten years).

(iv) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions shall apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services which assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

(k) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-063, filed 2/25/92, effective 3/27/92.]

WAC 284-66-066 Standard Medicare supplement benefit plans. (1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in WAC 284-66-063 (3)(k) and in WAC 284-66-073.

(3) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit shall be structured in accordance with the format provided in WAC 284-66-063(2) and 284-66-063(3) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the basic ("core") benefits common to all benefit plans, as defined at WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible as defined at WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" shall include only the following: The core benefit, as defined at

WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined at WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(h) Standardized Medicare supplement benefit plan "H" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined at WAC 284-66-063 (3)(a), (b), (f), and (h), respectively.

(i) Standardized Medicare supplement benefit plan "I" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively.

(j) Standardized Medicare supplement benefit plan "J" shall include only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined at WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively.

[Statutory Authority: RCW 48.02.060, 92-17-078 (Order R 92-7), § 284-66-066, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-066, filed 2/25/92, effective 3/27/92.]

WAC 284-66-073 Medicare SELECT policies and certificates. (1)(a) This section shall apply to Medicare SELECT policies and certificates, as defined in this section.

(b) No policy or certificate may be advertised as a

Medicare SELECT policy or certificate unless it meets the requirements of this section.

(2) For the purposes of this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare SELECT issuer or its network providers.

(b) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare SELECT policy or certificate with the administration, claims practices, or provision of services concerning a Medicare SELECT issuer or its network providers.

(c) "Medicare SELECT issuer" means an issuer offering, or seeking to offer, a Medicare SELECT policy or certificate.

(d) "Medicare SELECT policy" or "Medicare SELECT certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare SELECT policy.

(f) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare SELECT policy.

(3) The commissioner may authorize an issuer to offer a Medicare SELECT policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(4) A Medicare SELECT issuer shall not issue a Medicare SELECT policy or certificate in this state until its plan of operation has been approved by the commissioner.

(5) A Medicare SELECT issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(ii) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(A) To deliver adequately all services that are subject to a restricted network provision; or

(B) To make appropriate referrals.

(iii) There are written agreements with network providers describing specific responsibilities.

(iv) Emergency care is available twenty-four hours per day and seven days per week.

(v) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual

insured under a Medicare SELECT policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare SELECT policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be utilized.

(d) A description of the quality assurance program, including:

(i) The formal organizational structure;

(ii) The written criteria for selection, retention, and removal of network providers; and

(iii) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the issuer to comply with subsection (9) of this section.

(g) Any other information requested by the commissioner.

(6)(a) A Medicare SELECT issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after thirty days unless specifically disapproved.

(b) An updated list of network providers shall be filed with the commissioner at least quarterly.

(7) A Medicare SELECT policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(b) It is not reasonable to obtain such services through a network provider.

(8) A Medicare SELECT policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(9) A Medicare SELECT issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare SELECT policy or certificate to each applicant. This disclosure shall include at least the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare SELECT policy or certificate with:

(i) Other Medicare supplement policies or certificates offered by the issuer; and

(ii) Other Medicare SELECT policies or certificates.

(b) A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(g) A description of the Medicare SELECT issuer's quality assurance program and grievance procedure.

(10) Prior to the sale of a Medicare SELECT policy or certificate, a Medicare SELECT issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (9) of this section and that the applicant understands the restrictions of the Medicare SELECT policy or certificate.

(11) A Medicare SELECT issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(a) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(b) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(d) If a grievance is found to be valid, corrective action shall be taken promptly.

(e) All concerned parties shall be notified about the results of a grievance.

(f) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(12) At the time of initial purchase, a Medicare SELECT issuer shall make available to each applicant for a Medicare SELECT policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(13)(a) At the request of an individual insured under a Medicare SELECT policy or certificate, a Medicare SELECT issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare supplement policy or certificate has been in force for six months.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare SELECT policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs,

coverage for at-home recovery services, or coverage for Part B excess charges.

(14) Medicare SELECT policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare SELECT policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare SELECT program to be reauthorized under law or its substantial amendment.

(a) Each Medicare SELECT issuer shall make available to each individual insured under a Medicare SELECT policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare SELECT policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for Part B excess charges.

(15) A Medicare SELECT issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare SELECT program.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-073, filed 2/25/92, effective 3/27/92.]

WAC 284-66-077 Open enrollment. (1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six-month period beginning with the first month in which an individual (who is sixty-five years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(2) Subsection (1) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-077, filed 2/25/92, effective 3/27/92.]

WAC 284-66-080 Outline of coverage required. (1)

Issuers shall provide an outline of coverage to all applicants at the time an application is presented to the prospective applicant and, except for direct response policies and certificates, shall obtain an acknowledgement of receipt of such outline from the applicant.

(2) The "outline of coverage," shall be completed in substantially the form set forth in WAC 284-66-092. The form of outline of coverage shall be filed with the commissioner prior to use in this state.

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(4) The outline of coverage provided to applicants pursuant to this section consists of four parts: A cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in WAC 284-66-092 in no less than twelve point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(5) 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, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-080, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-080, filed 3/20/90, effective 4/20/90.]

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]
 Outline of Medicare Supplement Coverage-Cover Page:
 Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
 Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
 Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
 Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

(2) Disclosure page(s):

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An

issuer may use additional benefit plan designations on these charts pursuant to WAC 284-66-066(4).] cover page and in the chart, in a manner approved by the commissioner.]

[Include an explanation of any innovative benefits on the (3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$0 \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$[652] (Part A deductible) \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 \$0 \$0	\$0 Up to \$[81.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B deductible) \$0
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PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 \$0 \$0	\$0 Up to \$[81.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B deductible) \$0
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PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$100 (Part B deductible) Generally 20% \$0	\$0 \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$100 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$100 (Part B deductible) 20%	\$0 \$0 \$0
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PLAN C (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life- time maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day \$0 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	0	\$0

(continued)

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$100 of Medicare approved amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B deductible) \$0
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(continued)

PLAN E (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 life- time maximum
PREVENTIVE MEDICARE CARE BENEFIT-NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$100 (Part B deductible Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$100 (Part B deductible 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$100 (Part B deductible 20%	\$0 \$0 \$0
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PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life- time maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	\$100 (Part B deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$100 of Medicare approved amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B deductible) \$0
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(continued)

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50% - \$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All costs

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$100 (Part B deductible) \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$100 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN I (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment			
First \$100 of Medicare approved amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges*	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

PLAN I

OTHER BENEFITS - NOT COVERED BY MEDICARE (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BASIC OUTPATIENT PRE- SCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50% - \$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All costs

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	All but \$[652] All but \$[163] a day All but \$[326] a day \$0 \$0	\$[652] (Part A deductible) \$[163] a day \$[326] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$81.50]/day \$0	\$0 Up to \$[81.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0	\$100 (Part B deductible)	\$0
	Generally 80%	Generally 20%	\$0
	\$0	100%	\$0
BLOOD First 3 pints Next \$100 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0	All costs	\$0
	\$0	\$100 (Part B deductible)	\$0
	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN J (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
---Medically necessary skilled care services and medical supplies	100%	\$0	\$0
---Durable medical equipment First \$100 of Medicare approved amounts*	\$0	\$100 (Part B deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

(continued)

PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
EXTENDED OUTPATIENT PRE-SCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50% - \$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

[Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-092, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-092, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-110 Buyer's guide. (1) Issuers of disability insurance policies or certificates 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 such 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, or any reproduction or official revision of that pamphlet. The guide shall be printed in a style and with a type character that is easily read by an average person eligible for Medicare supplement insurance and in no case may the type size be smaller than 12-point type. (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 or certificates are advertised, solicited, or issued as Medicare supplement insurance policies or certificates.

(4) Except in the case of a direct response issuers, 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 issuer. Direct response issuers 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, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-110, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-110, filed 3/20/90, effective 4/20/90.]

WAC 284-66-120 Notice regarding policies which are not Medicare supplement policies. Any disability insurance policy or certificate (other than a Medicare supplement policy or certificate or a policy issued pursuant to a contract under Section 1876 or 1833 of the Social Security Act (42 U.S.C. Section 1395 et seq.), disability income protection policy, basic or comprehensive or major medical expense policy, or other policy identified in RCW 48.66.020(1), whether issued on an individual or group basis, which policy purports to provide coverage to residents of this state eligible for Medicare by reason of age, shall notify policyholders or certificate holders that the policy is not a Medicare supplement insurance policy or certificate. Such notice shall be printed or attached to the first page of the outline of coverage or equivalent disclosure form, and shall be delivered to the policyholder or certificate holder. If no outline of coverage is delivered, the notice shall be attached to the first page of the policy or certificate 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, certificate or subscriber contract). If you are eligible for Medicare, review the Medicare supplement Buyer's Guide available from the company."

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-120, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-120, filed 3/20/90, effective 4/20/90.]

WAC 284-66-130 Requirements for application forms and replacement of Medicare supplement insurance coverage. (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement insurance or other disability policy or certificate in force or whether a Medicare supplement insurance policy or certificate is intended to replace any other policy or certificate of a health care service contractor, health maintenance organization, disability insurer, or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements, may be used: *Provided, however,* That where the coverage is sold without an agent, the supplementary application shall be signed by the applicant.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you are sixty-five or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within ninety days of losing Medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[Questions]

To the best of your knowledge.

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(a) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(a) If so, with which company?

(b) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

(2) Agents shall list any other medical or health insurance policies sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five years which are no longer in force.

(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(4) Upon determining that a sale will involve replacement of Medicare Supplement Coverage, an issuer, other than a direct response issuer, 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 Medicare supplement insurance coverage. One copy of such notice, signed by the applicant and the agent (except where the coverage is sold without an agent), shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement insurance coverage.

(5) The notice required by subsection (4) of this section for an issuer, shall be provided in substantially the form set forth in WAC 284-66-142 in no smaller than ten point type, and shall be filed with the commissioner prior to use in this state.

(6) The notice required by subsection (4) of this section for a direct response insurer shall be in substantially the form set forth in WAC 284-66-142 and shall be filed with the commissioner prior to use in this state.

(7) A true copy of the application for a Medicare supplement insurance policy issued by a health maintenance organization or health care service contractor for delivery to a resident of this state must be attached to or otherwise physically made a part of the policy when issued and delivered.

(8) Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization may substitute appropriate terminology.

(9) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an

issuer if the replacement does not involve application of a new preexisting condition limitation.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-130, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-130, filed 3/20/90, effective 4/20/90.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-142 Form of replacement notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
No change in benefits, but lower premiums.
Fewer benefits and lower premiums.
Other. (please specify)

- 1. If you have had your current Medicare supplement policy less than six months, 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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.
3. If 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 and 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, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-142, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-160 Adjustment notice to conform existing Medicare supplement policies to changes in Medicare.

As soon as practicable, but no later than thirty days prior to the effective date of any Medicare benefit changes, every insurer providing Medicare supplement insurance coverage to a resident of this state shall notify its insureds of modifications it has made to Medicare supplement policies. The adjustment notice is intended to be informational only and for the sole purpose of informing policyholders and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The form of an adjustment notice provided to residents of this state shall be filed with the commissioner prior to use.

(1) The 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) The notice shall inform each covered person of the approximate date when premium adjustments due to changes in Medicare benefits will be made.

(3) The notice of benefit modifications and any premium changes shall be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice shall not contain or be accompanied by any solicitation.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-160, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110,

48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-160, filed 3/20/90, effective 4/20/90.]

WAC 284-66-170 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates. (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-170, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-170, filed 3/20/90, effective 4/20/90.]

WAC 284-66-200 Standards for loss ratios. The following standards apply to policies issued or delivered prior to July 1, 1992, unless such policies are approved under the standards of WAC 284-66-063 and 284-66-203. 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 loss ratios shall be on the basis of incurred claims losses 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.

(1) Where coverage is provided on a service rather than reimbursement basis, such loss ratios 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 and are not excessive, inadequate or unfairly discriminatory.

(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 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. If the period for which the policy is initially rated is more than one year, ratios of incurred losses to earned premiums shall be filed by number of years of policy duration. Supporting documentation shall include the amounts of unearned premium reserve, policy reserves, and claim reserves and liabilities, both nationally and for this state.

This annual filing is in addition to filings made by insurers to establish initial rates or request rate adjustments required by WAC 284-66-240.

(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) For issue age level premium rated policies, an expected loss ratio for the third policy year, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force fewer than three years. For community rated policies the applicable percentage shall be demonstrated for the three most recent accounting periods. The applicable percentage shall be as defined in subsection (6) or (7) of this section.

(d) For purposes of rate making and rate adjustments, similar policy forms shall be grouped together according to the rules set forth in WAC 284-60-040. All Medicare supplement policies of an issuer issued for delivery between January 1, 1989, and July 1, 1992, are considered "similar policy forms" except those forms specifically approved under the standards of WAC 284-66-063 and 284-66-203.

(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 authorized 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 requirements for health maintenance organizations and health care service contractors shall be seventy percent for individual forms and eighty percent for group contract forms. The minimum anticipated loss ratios are deemed to be met if the health care expense costs of the health maintenance organization or health care service contractor 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.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-200, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-200, filed 3/20/90, effective 4/20/90.]

WAC 284-66-203 Loss ratio and rating standards and refund or credit of premium. (1) Loss ratio and rating standards. For policies issued on or after July 1, 1992, and those policies specifically approved by the commissioner under WAC 284-66-063 prior to July 1, 1992:

(a) A Medicare supplement policy form or certificate form must be rated on an issue-age level premium basis or community rated basis, as described at WAC 284-66-243(6), in order to meet the standards of WAC 284-66-310.

(b) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization or health care service contractor on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

(c) All filing of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(d) For purposes of applying subsection (1)(b) of this section and WAC 284-66-243 (3)(c) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(2) Refund or credit calculation.

(a) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in WAC 284-66-232 for each type in a standard Medicare supplement benefit plan.

(b) If on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3) in year three or later, then a refund or credit calculation is required. The refund calculation shall be done on a state-wide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded. This subsection applies only to annual experience reporting. Any revision of premium rates must be filed with and approved by the commissioner in accordance with WAC 284-66-243.

(c) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit

at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) Annual filing of premium rates.

On or before May 31 of each calendar year, an issuer of standardized Medicare supplement policies and certificates issued in accordance with WAC 284-66-063, shall file its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner on the form provided at subsection (6) of this section. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

(4) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(a)(i) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(ii) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(iii) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(5) Public hearings.

(a) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for policy form or certificate form if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consider-

ation of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

(b) This section does not in any way restrict a com-mis-

sioner's statutory authority to approve or disapprove rates.
(6) Annual Medicare supplement insurance reporting form:

Annual Filing of Premium Rates and Experience To be filed on or before May 31 of each calendar year		
Experience from January 1 to December 31, of 19 _____ reported by duration for all business from inception to December 31, 19 _____.		
Company Name _____		
Address _____		
NAIC Group Code _____	NAIC Company Code _____	CIC Code _____
Plan _____	Type _____	Form No. _____
Premium Rates [Attach schedule]		
Insurance is [check one] Group _____ or Individual _____		
Washington Experience. [Show all experience for the reported calendar year (separately for each duration).]		
<u>Policy Duration</u>	<u>Incurred Losses</u>	<u>Earned Premiums</u>
		<u>Loss Ratio</u>
		<u>Claim Reserves</u>
I hereby certify that I have supervised the preparation of this experience exhibit, that all durational information has been furnished, and to the best of my knowledge the data is accurate and is in compliance with RCW 48.66.150 and WAC 284-66-203.		
_____ Signature of Officer	_____ Date	
_____ Name and Title of Officer	_____ Prepared by	
_____ Phone Number	_____ Phone Number	

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-203, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-210 Policy reserves required. This section shall apply to every group and individual policy of an issuer which relates its benefits to Medicare. The term "policy reserve" is intended to apply to all types and forms of insurance equally, whether they are called policies, contracts, or certificates. For all forms which are issued on a level premium basis, policy reserves will be required. The policy reserve is in addition to claim reserves and premium reserves. The definition of the date of incurral must be the same for both claim reserves and policy reserves. Policy reserves shall be based upon the following minimum standards:

(1) Morbidity should be based upon a reasonable expectation of future claim costs for the benefits being provided. At time of policy issue this would be the morbidity assumptions used to price the contract. For later durations the morbidity should reflect the experience which emerges including the effects of inflation and utilization. All morbidity assumptions must be reasonable in the view of the commissioner.

(2) The interest rate used may not exceed the maximum rate permitted by statute in the valuation of life insurance issued on the same date as the Medicare supplement policy.

(3) Termination rates shall be on the same basis as the mortality table permitted by statute in the valuation of life insurance issued on the same date as the Medicare supplement policy or on another basis satisfactory to the commissioner.

(4) The minimum reserve is that calculated on the one-year full preliminary term method. This method produces a terminal reserve of zero at the first policy anniversary. The preliminary term method may be applied only in relation to the date of issue of a policy. Reserve adjustments introduced later as a result of rate increases, revisions in assumptions, or for other reasons, are to be applied immediately as of the effective date of adoption of the adjusted basis. Such adjustments shall be determined as follows:

(a) Present value of future payments of claim costs for benefits, determined using revised assumptions based on anticipated experience;

(b) Less the present value of future net premiums, determined using revised assumptions based on anticipated experience;

(c) Less the liability for contract reserves at the valuation date.

(5) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy or contract, but the total policy reserve with respect to all benefits combined may not be less than zero.

(6) The minimum policy reserve shall include a reasonable margin for the risk of adverse selection.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-210, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460,

48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-210, filed 3/20/90, effective 4/20/90.]

WAC 284-66-220 Medicare supplement refund calculation form required. The form provided in WAC 284-66-232 shall be filed with the commissioner annually not later than May 31st of each calendar year beginning May 31, 1993. The form is to be filed in addition to the NAIC experience exhibit and not in lieu thereof.

[Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-220, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-220, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-220, filed 3/20/90, effective 4/20/90.]

WAC 284-66-232 Form for Medicare supplement refund calculation.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP(w) _____
 For the State of _____
 Washington Policy or Certificate Form No(s). _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number _____

Line	(a) Earned Premium (x)	(b) Incurred Claims (y)
1. Current Year's Experience a. Total (all policy years) b. Current year's issues (z) c. Net (for reporting purposes = 1a - 1b)		
2. Past Years' Experience (All Policy Years)		
3. Total experience (Net Current Year + Past Years' Experience)		
4. Refunds Last year (Excluding Interest)		
5. Previous Since Inception (Excluding Interest)		
6. Refunds Since Inception (Excluding Interest)		
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8. Experienced Ratio Since Inception $\frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6)}} = \text{Ratio 2}$		
9. Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10. Tolerance Permitted (obtained from credibility table)		
11. Adjustment to incurred Claims for Credibility $\text{Ratio 3} = \text{Ratio 2} + \text{Tolerance}$ If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the benchmark ratio, then proceed.		

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP(w) _____
 For the State of _____
 Washington Policy or Certificate Form No(s). _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number _____

Line	(a) Earned Premium (x)	(b) Incurred Claims (y)
12. Adjust Incurred Claims = [Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)] X Ratio 3 (line 11)		
13. Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) - <u>Adjusted Incurred Claims (line 12)</u> <u>Benchmark Ratio (Ratio 1)</u> If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.		

Medicare Supplement Credibility Table

Life Year Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If Less than 500	No credibility

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP(w) _____
For the State of _____
Washington Policy or Certificate Form No(s). _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes modal loadings and fees charged.
- (y) Excludes Active Life Reserves.
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name - Please Type

Title

Date

WORKSHEET #1 - INDIVIDUAL POLICIES

REPORTING FORM FOR TIME CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (P) _____
FOR THE STATE OF WASHINGTON _____
Washington Policy or Certificate Form No. _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n) / (k + m)$:
(a) Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b) For the calendar year on the appropriate line in column (a),
the premium earned during that year for policies issued in that year.

(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

k = Total of Column "d"
l = Total of Column "f"
m = Total of Column "h"
n = Total of Column "j"

(o) These loss ratios are not explicitly used in computing the benchmark loss ratios.
They are the loss ratios, on a policy year basis, which result in the commulative
loss ratio displayed on this worksheet. They are shown here for informational purposes only.

WORKSHEET #1 - GROUP POLICIES

REPORTING FORM FOR TIME CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR ____

TYPE _____ SMSBP (P) _____
FOR THE STATE OF WASHINGTON
Washington Policy or Certificate Form No. _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n) / (k + m)$
(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a),
the premium earned during that year for policies issued in that year.
(p) "SMSBP" = Standardized Medicare Supplement Benefit Plan

k = Total of Column "d"
l = Total of Column "f"
m = Total of Column "h"
n = Total of Column "j"

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios.
They are the loss ratios, on a policy year basis, which result in the cumulative
loss ratio displayed on this worksheet. They are shown here for informational purposes only.

[Statutory Authority: RCW 48.02.060, 93-01-048 (Order 92-25), § 284-66-232, filed 12/10/92, effective 1/10/93. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-232, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-240 Filing requirements and premium adjustments. (1) Unless such forms meet the standards of WAC 284-66-063 and 284-66-203, all policy forms issued or delivered on or after January 1, 1990, and before July 1, 1992, as well as any future rate adjustment thereto, shall demonstrate compliance with the loss ratio requirements of WAC 284-66-200 and policy reserve requirements of WAC

284-66-210. All filings of rate adjustments shall be accompanied by the proposed rate schedule and an actuarial memorandum completed and signed by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter. If any of the items listed below are inappropriate due to the pricing methodology utilized by the pricing actuary, the commissioner may waive the requirements upon request of the issuer.

(a) Filings of issue age level premium rates shall be accompanied by the following:

(i) Anticipated loss ratios stated on a policy year basis for the period for which the policy is rated. Filings of future rate adjustments must contain the actual policy year loss ratios experienced since inception;

(ii) Anticipated total termination rates on a policy year basis for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a policy year basis since inception;

(iii) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(iv) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(v) Specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general agents, or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies, such agreements demonstrating compliance with WAC 284-66-350 (where appropriate);

(vi) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

(b) Filings of community rated forms shall be accompanied by the following:

(i) Anticipated loss ratio for the accounting period for which the policy is rated. The duration of the accounting period must be stated in the filing, established based on the judgment of the pricing actuary, and must be reasonable in the opinion of the commissioner. Filings for rate adjustment must demonstrate that the actual loss ratios experienced during the three most recent accounting periods, on an aggregated basis, have been equal to or greater than the loss ratios required by WAC 284-66-200.

(ii) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(iii) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(iv) Specimen copy of the compensation agreements or contracts between the insurer and its agents, brokers, general agents, or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies, such agreements demonstrating compliance with WAC 284-66-350 (where appropriate);

(v) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

(2) Every issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such

policy as will conform with the minimum loss ratio standards of WAC 284-66-200.

(3) 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.

(4) Premium refunds or premium credits shall be made to the premium payer 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.

(5) For purposes of rate making and requests for rate increases, all individual Medicare supplement policy forms of an issuer are considered "similar policy forms" including forms no longer being marketed.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-240, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-240, filed 3/20/90, effective 4/20/90.]

WAC 284-66-243 Filing and approval of policies and certificates and premium rates. (1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(3)(a) Except as provided in (b) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(b) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(i) The inclusion of new or innovative benefits;

(ii) The addition of either direct response or agent marketing methods;

(iii) The addition of either guaranteed issue or underwritten coverage;

(iv) The offering of coverage to individuals eligible for Medicare by reason of disability.

(c) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare SELECT policy, or a group Medicare SELECT policy.

(4)(a) Except as provided in (a)(i) of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form pursuant to (a)(i) of this subsection, shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology shall be considered a discontinuance under (a) of this subsection, unless the issuer complies with the following requirements:

(i) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(5)(a) Except as provided in (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(6) An issuer may set rates only on a community rated basis or on an issue-age level premium basis.

(a) Community rated premiums shall be equal for all individual policyholders or certificateholders under a standardized Medicare supplement benefit form. Such premiums may not vary by age or sex.

(b) Issue-age level premiums must be calculated for the lifetime of the insured. This will result in a level premium if the effects of inflation are ignored.

(7) All filings of policy or certificate forms shall be accompanied by the proposed application form, outline of coverage form, proposed rate schedule, and an actuarial memorandum completed, signed and dated by a qualified actuary as defined in WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter:

(a) Anticipated loss ratios stated on a calendar year basis by duration for the period for which the policy is rated. Filings of future rate adjustments must contain the actual calendar year loss ratios experienced since inception, both before and after the refund required, if any;

(b) Anticipated total termination rates on a calendar year basis by duration for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a calendar year basis since inception;

(c) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(d) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(e) A complete specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general agents, as well as the contracts between general agents and agents or others whose compensation is based in whole or in part on the sale of Medicare supplement insurance policies. Such agreements shall demonstrate compliance with WAC 284-66-350 (where appropriate);

(f) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-243, filed 2/25/92, effective 3/27/92.]

WAC 284-66-250 Filing requirements for out-of-state group policies. Every issuer providing group Medicare supplement insurance benefits to a resident of this state shall file with the commissioner, within thirty days of its use in this state, a copy of the master policy and any certificate used in this state, in accordance with the filing requirements and procedures applicable to Medicare supplement policies issued in this state.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-250, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-250, filed 3/20/90, effective 4/20/90.]

WAC 284-66-260 Riders and endorsements. (1) 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 modifying contractual benefits may be used by an issuer to exclude, limit, or reduce the coverage or benefits of a Medicare supplement insurance policy or certificate issued to a resident of this state. Only riders or endorsements which increase benefits or coverage may be used in this state.

(2) Effective January 1, 1990, except for riders or endorsements issued to bring a policy into compliance with changes to the minimum benefit standards or other contractual benefits required by this chapter or as hereafter amended:

(a) An amendment to a Medicare supplement insurance policy or certificate which increases the premium must be requested or accepted by the policyholder in writing; and

(b) Where separate additional premium is charged for a rider, endorsement or other amendment to the contractual benefits of a Medicare supplement insurance policy or certificate, the premium charged shall be set forth in the policy.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-260, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-260, filed 3/20/90, effective 4/20/90.]

WAC 284-66-270 Standards for claims payment: Compliance with Omnibus Budget Reconciliation Act of 1987. (1) An issuer shall comply with Section 1882 (c)(3) of the Social Security Act (as enacted by Section 4081 (b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA'87), P.L. 100-203) by:

(a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the requirements set forth in subsection (1) of this section shall be certified on the Medicare supplement insurance experience reporting form.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-270, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-270, filed 3/20/90, effective 4/20/90.]

WAC 284-66-300 Requirements for advertising. (1)

At least thirty days prior to use in this state, every issuer who provides Medicare supplement insurance coverage to a resident of this state shall provide the commissioner with a copy of any Medicare supplement advertisement (as advertisement is defined in 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 cassette shall be supplied on request of the commissioner.

(2) Advertising shall comply with the standards of the Washington disability advertising regulation (WAC 284-50-010 through 284-50-230), and shall set forth the name in full of the issuer and the location of its home office or principal office in the United States (if an alien issuer).

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-300, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-300, filed 3/20/90, effective 4/20/90.]

WAC 284-66-310 Attained age rating prohibited.

With respect to Medicare supplement insurance policies and certificates initially sold to residents of this state on or after January 1, 1989, the commissioner has found and hereby defines it to be an unfair act or practice and an unfair method of competition, and a prohibited practice, for any issuer, directly or indirectly, to use the increasing age of an insured, subscriber, or participant as the basis for increasing premiums or prepayment charges. Accordingly, the rating practice commonly referred to as "attained age rating" is prohibited.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-310, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-310, filed 3/20/90, effective 4/20/90.]

WAC 284-66-320 Reporting of multiple policies.

(1) On or before March 1st of each year, an issuer shall report to the commissioner the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate on a form approved by the commissioner, substantially in the form provided in WAC 284-66-323:

(a) Policy and certificate number; and

(b) Date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-320, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-320, filed 3/20/90, effective 4/20/90.]

WAC 284-66-323 Form for reporting multiple Medicare supplement policies and certificates.
Medicare Supplement Regulation

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and
Certificate #

Date of
Issuance

Signature

Name and Title (please type)

Date

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-323, filed 2/25/92, effective 3/27/92.]

WAC 284-66-330 Standards for marketing. (1)

Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, shall:

(a) Establish marketing procedures to assure that any comparison of policies or certificates by its agents or other producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp or other appropriate means, on the first page of the policy or certificate the following:

"NOTICE TO BUYER: THIS (POLICY, CONTRACT OR CERTIFICATE) MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has disability insurance and the types and amounts of any such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

(2) In addition to the acts and practices prohibited in chapter 48.30 RCW, chapters 284-30 and 284-50 WAC, and this chapter, the commissioner has found and hereby defines the following to be unfair acts or practices and unfair methods of competition, and prohibited practices for any issuer, or their respective agents either directly or indirectly:

(a) Twisting. Making misrepresentations or misleading comparisons of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, or convert any insurance policy.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or otherwise applying undue pressure to coerce the purchase of, or recommend the purchase of, insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-330, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-330, filed 3/20/90, effective 4/20/90.]

WAC 284-66-340 Appropriateness of recommended purchase and excessive insurance. (1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of Medicare supplement coverage which will provide an individual more than one Medicare supplement policy or certificate is prohibited.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-340, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-340, filed 3/20/90, effective 4/20/90.]

WAC 284-66-350 Permitted compensation arrangements. (1)(a) The commissioner has found and hereby defines it to be an unfair act or practice and an unfair method of competition, and a prohibited practice, for any issuer, directly or indirectly, to provide commission to an agent or other representative for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate which is delivered or issued for delivery to a resident within this state unless the commission is identical as to percentage of premium for every policy year as long as the coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for such coverage.

(b) Each commission payment must be made by the issuer no later than sixty days following the date on which the applicable premiums, upon which the commission is calculated, were paid. Each such payment must be paid to either the producing agent who originally sold the policy or to a successor agent designated by the issuer to replace the producing agent, or shared between them on some basis. The distribution of the commission payments shall be designated by the issuer in its various agents' commission agreements and it may not terminate, reduce or retain the commission payment as long as the policy or certificate remains in force with premiums being paid, or waived by the issuer, for the coverage thereunder.

(c) Where an issuer provides a portion of the total commission for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate to a general agent, sales manager, district representative or other supervisor who has marketing responsibilities (other than a producing or successor agent), while such portion of total commissions continues to be paid it shall be identical as to percentage of premium for every policy year as long as coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for such coverage.

(2) For purposes of this section, "commission" includes pecuniary or nonpecuniary remuneration of any kind relating to the solicitation, sale, servicing, or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, advances on commissions, awards and finders fees.

(3) This section shall not apply to salaried employees of an issuer who have marketing responsibilities if the salaried employee is not compensated, directly or indirectly, on any basis dependent upon the sale of insurance being made, including but not limited to considerations of the number of applications submitted, the amount or types of insurance, or premium volume.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-350, filed 2/25/92, effective

3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-350, filed 3/20/90, effective 4/20/90.]

WAC 284-66-400 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate Medicare supplement insurance policies or certificates under other sections of Title 48 RCW.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-400, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-400, filed 3/20/90, effective 4/20/90.]

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 certain 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 certain 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. However, if the gender blended smoker and nonsmoker mortality tables are used to determine cash surrender values and paid-up nonforfeiture benefits then pursuant to WAC 284-74-100 (4)(c) the smoker and nonsmoker mortality tables shall be used to determine minimum reserve liabilities.

(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.

(h) As used in this section, "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" means the mortality tables with separate rates of mortality for smokers and nonsmokers which is found in NAIC Proceedings, 1984, Vol. I, pp. 406-413 and which is derived from the 1980 CSO and 1980 CET Mortality Tables.

(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, 1984, 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) In determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of chapter 48.76 RCW for that policy form, in addition to the mortality tables that may be used according to subsection (2) of this section:

(a) A mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, 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; and

(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 male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 CET table.

The following blended mortality tables found in NAIC Proceedings, 1981, Vol. I, pp. 406-413 and NAIC Proceedings, 1987, Vol. I, 521-530, will be considered acceptable:

SA: 100% Male 0% Female smoker tables designated as "1980 CSO-SA" and "1980 CET-SA" tables.

SB: 80% Male 20% Female smoker tables designated as "1980 CSO-SB" and "1980 CET-SB" tables.

SC: 60% Male 40% Female smoker tables designated as "1980 CSO-SC" and "1980 CET-SC" tables.

- SD: 50% Male 50% Female smoker tables designated as "1980 CSO-SD" and "1980 CET-SD" tables.
- SE: 40% Male 60% Female smoker tables designated as "1980 CSO-SE" and "1980 CET-SE" tables.
- SF: 20% Male 80% Female smoker tables designated as "1980 CSO-SF" and "1980 CET-SF" tables.
- SG: 0% Male 100% Female smoker tables designated as "1980 CSO-SG" and "1980 CET-SG" tables.
- NA: 100% Male 0% Female nonsmoker tables designated as "1980 CSO-NA" and "1980 CET-NA" tables.
- NB: 80% Male 20% Female nonsmoker tables designated as "1980 CSO-NB" and "1980 CET-NB" tables.
- NC: 60% Male 40% Female nonsmoker tables designated as "1980 CSO-NC" and "1980 CET-NC" tables.
- ND: 50% Male 50% Female nonsmoker tables designated as "1980 CSO-ND" and "1980 CET-ND" tables.
- NE: 40% Male 60% Female nonsmoker tables designated as "1980 CSO-NE" and "1980 CET-NE" tables.
- NF: 20% Male 80% Female nonsmoker tables designated as "1980 CSO-NF" and "1980 CET-NF" tables.
- NG: 0% Male 100% Female nonsmoker tables designated as "1980 CSO-NG" and "1980 CET-NG" tables.

Tables SA, SG, NA, and NG are not acceptable as blended tables unless the proportion of persons insured is anticipated to be 90% or more of one sex or the other.

(7) 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. 89-03-031 (Order R 89-1), § 284-74-200, filed 1/11/89; 88-04-054 (Order R 88-1), § 284-74-200, filed 1/29/88, effective 2/29/88.]

Chapter 284-78 WAC

JOINT UNDERWRITING ASSOCIATION FOR DAY CARE INSURANCE

WAC

284-78-010	Purpose.
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284-78-050	Administration.
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284-78-090	Eligibility of licensees for coverage.
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284-78-150	Commissions.
284-78-160	Additional notice required.
284-78-170	Termination of association.
284-78-180	Effective date.

WAC 284-78-010 Purpose. The purpose of this chapter is to establish a joint underwriting association pursuant to chapter 141, Laws of 1986, to provide liability insurance for day care services.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-010, filed 8/29/86.]

WAC 284-78-020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Insurer" means any insurance company that, on or after July 1, 1986, possesses a certificate of authority to write property and casualty insurance within this state on a direct basis.

(2) "Day care insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of negligence or malpractice in rendering professional service by any licensee.

(3) "Association" means the joint underwriting association established pursuant to the provisions of chapter 141, Laws of 1986.

(4) "Licensee" means any person or facility licensed to provide day care services pursuant to chapter 74.15 RCW.

(5) "Commissioner" means the insurance commissioner of the state of Washington.

(6) "Service insurer" means any insurance company designated by the association and approved by the commissioner to issue policies pursuant to this chapter.

(7) "Board" means the governing board of the association.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-020, filed 8/29/86.]

WAC 284-78-030 The association. (1) A nonprofit joint underwriting association for day care insurance is hereby established. Membership in the association shall be mandatory for all insurers that on or after July 1, 1986, possess a certificate of authority to write property and casualty insurance within this state on a direct basis. Every such insurer shall be and remain a member of the association and fulfill all its membership obligations as a condition of its authority to continue to transact property and casualty insurance business in this state.

(2) The association shall remain inactive, except for the actions of the board enumerated in WAC 284-78-050 through 284-78-080, until it is activated by the commissioner as provided in WAC 284-78-040.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-030, filed 8/29/86.]

WAC 284-78-040 Activation of association. If the commissioner finds that any licensee is unable to obtain day care insurance with liability limits of at least one hundred thousand dollars per occurrence from the voluntary insurance market, or through any market assistance plan organized pursuant to section 906, chapter 305, Laws of 1986, the commissioner may notify the board in writing of such finding and may direct the board to activate the association and commence writing day care insurance within thirty days

of receipt of the notice in accordance with the provisions of these regulations.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-040, filed 8/29/86.]

WAC 284-78-050 Administration. (1) The association shall be administered by a governing board, subject to the supervision of the commissioner, and operated by a manager appointed by the board.

(2) The board shall consist of nine members. Five board members shall be insurers, one of which shall be appointed by the commissioner from each of the following: American Insurance Association, Alliance of American Insurers, National Association of Independent Insurers, all other stock insurers, and all other nonstock insurers. A sixth board member shall be the insurer designated as the service insurer for the association (or, if there is more than one service insurer, the sixth board member shall be such service insurer as the commissioner designates as the board member). The other three board members shall be licensees who are appointed by the commissioner to so serve, none of whom shall be interested, directly or indirectly, in any insurer except as a policyholder. Board members shall serve for a period of one year or until their successors are appointed. Not more than one insurer in a group under the same management or ownership shall serve on the board at the same time. At least one of the six insurers on the board shall be a domestic insurer. All members of the board shall serve at the pleasure of the commissioner.

(3) Each person serving on the board or any subcommittee thereof, each member insurer of the association, and each officer and employee of the association shall be indemnified by the association against all costs and expenses actually and necessarily incurred by him, her, or it in connection with the defense of any action, suit, or proceeding in which he, she, or it is made a party by reason of his, her, or its being or having been a member of the board, or a member or officer or employee of the association, except in relation to matters as to which he, she, or it has been judged in such action, suit, or proceeding to be liable by reason of wilful misconduct in the performance of his, her, or its duties as a member of such board, or member, officer, or employee of the association. This indemnification shall not be exclusive of other rights as to which such member, or officer, or employee may be entitled as a matter of law.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-050, filed 8/29/86.]

WAC 284-78-060 General powers and duties of the board. (1) Within thirty days after the appointment of its members by the commissioner, the board shall prepare and adopt articles of association consistent with this chapter, subject to approval by the commissioner. In a timely manner thereafter, the board shall take all actions necessary to prepare the association to receive applications and issue policies, when and if the commissioner activates the association as provided in WAC 284-78-040. These actions shall include the preparation of all necessary policy forms and rating information to be filed with the commissioner for approval and all necessary operating manuals and procedures to be followed.

(2) The board shall meet as often as may be required to perform the general duties of the administration of the association or on the call of the commissioner. Three insurer members of the board shall constitute a quorum.

(3) The board may appoint a manager, who shall serve at the pleasure of the board, to perform any duties necessary or incidental to the proper administration of the association, including the hiring of necessary staff.

(4) The board shall annually furnish to all insurer members of the association and to the commissioner a written report of operations.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-060, filed 8/29/86.]

WAC 284-78-070 Assessments. (1) The board may calculate, levy, and collect assessments from member insurers whenever necessary for the orderly operation of the association.

(2) After its formation, the board may calculate, levy, and collect from member insurers a start-up assessment to pay initial expenses of the association and to establish any necessary reserves. The start-up assessment shall not exceed one million dollars. For ease of administration, the share of the start-up assessment levied upon and collected from each member insurer shall be the same for each member insurer, regardless of size and regardless of whether it is actively writing business in this state.

(3) Any assessment subsequent to the initial start-up assessment shall be used to offset losses and/or expenses in excess of income received by the association. These assessments may be made as often as the board determines is necessary. To the extent such an assessment exceeds one million dollars, each member insurer shall be assessed a proportionate share relating to premium volume. The first one million dollars of such an assessment shall be levied and collected in equal amounts from each member insurer.

(4) Any member insurer failing to remit its assessment when due is subject to revocation of its certificate of authority to write property and casualty insurance in this state.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-070, filed 8/29/86.]

WAC 284-78-080 Statistics, records, and reports.

(1) The association shall maintain separate statistics on business written and shall make the following quarterly report to the commissioner:

- (a) Number of applications received by the association;
- (b) Number of applications accepted by the association and the total and average premiums charged, including the high and low premiums;
- (c) Number of risks declined;
- (d) Number of risks conditionally declined and the number ultimately accepted after having been conditionally declined; and
- (e) Number of risks cancelled.

(2) In addition to statistics, the association shall maintain complete and separate records of all business transactions, including copies of all policies and endorsements issued by the association, and records of reasons provided for each declination of coverage or cancellation of coverage,

including the results of any on-site inspections, or investigations of applicants or insureds or their employees.

(3) Regular reports of the association's operations shall be submitted to all members of the board, such reports to include, but not necessarily to be limited to, premiums written and earned, losses, including loss adjustment expense, paid and incurred, all other expenses incurred, outstanding liabilities, and, at least once a year, the proposed annual budget of the association for the next fiscal year.

(4) The books of account, records, reports, and other documents of the associations shall be open to the commissioner for examination at all reasonable times.

(5) The books of account, records, reports, and other documents of the association shall be open to inspection by members only at such times and under such conditions as the board shall determine.

(6) The books of account of any and all servicing insurers may be audited by a firm of independent auditors designated by the board.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-080, filed 8/29/86.]

WAC 284-78-090 Eligibility of licensees for coverage. Any licensee that is unable to obtain day care insurance with liability limits of at least one hundred thousand dollars per occurrence from the voluntary insurance market or from any market assistance plan organized pursuant to section 906, chapter 305, Laws of 1986, is eligible to apply for coverage through the association. The association's service insurer shall promptly process such application and, if the licensee is judged to be an acceptable insurable risk, offer coverage to the licensee. In view of the purpose of chapter 141, Laws of 1986, every licensee will be presumed to be an acceptable insurable risk for the association. To refuse coverage to any licensee meeting the other eligibility requirements of this section, the association must have the prior written approval of the commissioner. The commissioner will grant such approval only if the association demonstrates that extraordinary circumstances justify refusing coverage to such individual licensee.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-090, filed 8/29/86.]

WAC 284-78-100 Standard policy coverage—Premiums. (1) All policies issued by the association shall have liability limits of at least one hundred thousand dollars per occurrence and shall be issued for a term of one year.

(2) Premiums shall be based on the association's rate filings approved by the commissioner in accordance with chapter 48.19 RCW. Such rate filings shall provide for modification of rates for licensees according to the type, size, and past loss experience of each licensee, and any other differences among licensees that can be demonstrated to have a probable effect upon losses.

(3) A policy shall be offered which provides liability coverage with respect to child abuse, whether a sexual nature or not. In the discretion of the association, such policy may exclude from coverage an individual who directly commits or participates in the actual abuse, but it may not exclude from coverage other persons who may be liable only vicariously for such abuse. In addition, the association may

offer coverage with a broader exclusion with respect to coverage for child abuse.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-100, filed 8/29/86.]

WAC 284-78-110 Renewal of policies. (1) Policies written by the association will not automatically renew. To obtain continuing coverage by the association, a licensee must again satisfy initial eligibility requirements under WAC 284-78-090 at the end of the expiring policy term.

(2) The association shall notify covered licensees at least forty-five days prior to the expiration of a policy term of the need to submit a new application for coverage to the association to continue coverage.

(3) If the association fails to provide the required notice, the existing policy shall continue in force until the association has provided the required notice. In such case, premium shall be charged the licensee on a pro rata basis for coverage during the extended coverage period.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-110, filed 8/29/86.]

WAC 284-78-120 Cancellation of policies. (1) No policy or binder issued pursuant to this chapter shall be cancelled except:

(a) For nonpayment of premium, in which case cancellation of the policy shall be effected by providing ten days written notice in advance of the date of cancellation. Payment to the association of all premiums due, prior to the effective date of the cancellation, shall continue coverage as if no cancellation notice had been issued; or

(b) With the prior written approval of the commissioner upon the request of the board, for cause which would have been grounds for refusal of coverage under WAC 284-78-090.

(2) Notice of cancellation, accompanied by the actual reason therefor, shall be sent to the named insured.

(3) Any cancellation notice sent to the named insured shall be accompanied by a statement that the named insured has a right of appeal to the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-120, filed 8/29/86.]

WAC 284-78-130 Right of appeal. (1) Any applicant or insured, currently licensed pursuant to chapter 74.15 RCW, shall have a right of appeal to the commissioner, including the right to appear personally before the commissioner or his or her designee, if requested by the person seeking appeal, from any decision by the board to deny, cancel, or nonrenew coverage.

(2) Appeals to the commissioner under this provision shall be handled in accordance with chapters 48.04 and 34.04 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-130, filed 8/29/86.]

WAC 284-78-140 Cooperation of producers. All licensed insurance agents and brokers shall provide full cooperation in carrying out the aims and the operation of the association.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-140, filed 8/29/86.]

WAC 284-78-150 Commissions. The association shall pay commissions as established by the board on policies issued pursuant to this chapter to the licensed agent or broker designated by the applicant.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-150, filed 8/29/86.]

WAC 284-78-160 Additional notice required. Any notice of cancellation or nonrenewal of day care insurance given by an insurer to a licensee potentially eligible for coverage through the association shall include or be accompanied by an explanation of the licensee's right and procedure to obtain insurance through the association.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-160, filed 8/29/86.]

WAC 284-78-170 Termination of association. The association shall have perpetual existence, subject to repeal or modification of this chapter.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-170, filed 8/29/86.]

WAC 284-78-180 Effective date. This chapter is effective July 1, 1986.

[Statutory Authority: RCW 48.02.060 (3)(a). 86-18-043 (Order R 86-3), § 284-78-180, filed 8/29/86.]

Chapter 284-84 WAC

FIXED PREMIUM UNIVERSAL LIFE INSURANCE

WAC

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

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

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

(3) This chapter defines unfair practices and disclosure requirements in connection with the separate accumulation of policy values granted in a rider and attached to, granted

in a separate policy provision or incorporated in fixed premium universal life insurance policy forms. This chapter does not define minimum nonforfeiture provisions for the separate accumulation of funds or policy values attached to, separately granted or incorporated in fixed premium universal life insurance policy forms.

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

(5) This chapter does not apply to policy forms defined under chapter 48.18A RCW.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-010, filed 12/20/85.]

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

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

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

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

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

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

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

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

(8) "Death benefit corridor" defines a minimum policy benefit payable in addition to its cash value in the event of the death of the insured.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-020, filed 12/20/85.]

WAC 284-84-030 Commissioner's reserve valuation method. The minimum valuation standard for universal life insurance policies shall be the commissioner's reserve valuation method.

tion method, as hereinafter described for such policies, and the tables and interest rates hereinafter specified. The terminal reserve for the basic policy and any benefits and/or riders for which premiums are not paid separately as of any policy anniversary shall be equal to the net level premium reserves less (C) and less (D), where:

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

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

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

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

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

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

(f) r is equal to one.

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

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

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

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

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

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

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

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

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

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

(8) RCW 48.74.030 (1)(g) permits valuation calculations on the basis of substandard mortality. While such provisions have been used infrequently in the past, it is anticipated that substandard mortality will be more frequently utilized in universal life insurance, given its flexible nature, to reflect the mortality classification assigned to the policy by the insurer.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-030, filed 12/20/85.]

WAC 284-84-040 Alternate minimum reserves. (1)

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

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

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

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

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

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

(1) Reserves, as calculated without regard to this section, may, under some circumstances, be less than the cash surrender value or the policy value. In such instances, the reserves shall be increased to be equal to the largest of the cash surrender value, the reserve for the policy value less the surrender charges or the policy reserve. The policy value, to the extent it is guaranteed in the present and future years, shall be prefunded in accordance with the principles of the commissioner's reserve valuation method. The policy reserve shall be calculated by the commissioner's reserve valuation method for the fixed premium fixed benefit plan with all present values based on the most conservative of the mortality and interest assumptions defined by the policy guarantees for the purpose of defining benefits, or for the purpose of valuation.

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

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

(4) Reserves for policies where the policy value is provided in a separate policy provision shall employ the cash surrender value in the testing of such value pursuant to subsection (2) of this section and reserve for the policy value separately.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-050, filed 12/20/85.]

WAC 284-84-060 Minimum cash surrender values for fixed premium universal life insurance policies.

(1) The minimum cash surrender values shall be determined separately for the basic policy and any benefits and riders for which premiums are paid separately. The following requirements pertain to a basic policy and any benefits and riders for which premiums are not paid separately.

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

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

(ii) (B) is the present value of future adjusted premiums. The adjusted premiums are calculated as described in RCW 48.76.050 (1) and (2), or in (4)(a), as applicable. If RCW 48.76.050 (4)(a) is applicable, the nonforfeiture net level

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

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

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

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

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

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

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

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

nonforfeiture benefits must be available for election by the policyowner for at least sixty days after the due date of the premium in default.

(3) Nonforfeiture benefits for substandard issues. The cash and nonforfeiture values of a substandard issue shall be calculated according to the same principles and formulas as the standard issues affording equitable treatment of the several classes of insureds.

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-060, filed 12/20/85.]

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

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

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

(3) Policy guarantees. The policy shall contain:

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

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

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

(a) The guaranteed maximum expense charges and loads;

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

(c) The guaranteed maximum mortality charges;

(d) The guaranteed morbidity charges, if any;

(e) Any other guaranteed charges; and

(f) Any surrender or partial withdrawal charges.

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

(6) If the policyowner has the right to change the basic coverage, any limitation on the amount or timing of such change shall be stated in the policy. If the policyowner has the right to increase the basic coverage, the policy shall state whether a new period of contestability and/or suicide is applicable to the additional coverage.

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

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

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

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

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

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

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

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

(15) The brief description on the face page shall contain the words "universal life insurance."

[Statutory Authority: RCW 48.02.060. 86-02-011 (Order R 85-5), § 284-84-070, filed 12/20/85.]

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

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

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

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

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

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

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

(4) Any illustration of the policy benefits based upon nonguaranteed interest, mortality, morbidity, expense charges and loads, other current charges, current surrender or partial withdrawal charges shall be accompanied by a prominent statement indicating that these benefits are not guaranteed.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-080, filed 12/20/85.]

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

Such report shall include the following:

- (1) The beginning and ending dates of the current report period;
- (2) The policy value at the end of the previous report period and at the end of the current report period;
- (3) The rate of interest applied to the policy value and the total amounts which have been credited or debited to the policy value during the current report period, identifying each by type (for example, interest, mortality, expense and riders);
- (4) The current death benefit at the end of the current report period on each life covered by the policy;
- (5) The cash surrender value and the net cash surrender value of the policy as of the end of the current report period; and
- (6) The amount of outstanding loans, if any, as of the end of the current report period; and
- (7) If, assuming guaranteed interest, mortality and expense loads and continued scheduled premium payments, the policy's net cash surrender value is such that it would not maintain insurance in force until the end of the next reporting period, a notice to this effect shall be included in the report.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-090, filed 12/20/85.]

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

- (1) Contrive to set the premiums at the time of repricing so as to reduce, postpone or avoid cash values.
- (2) Recoup past losses or distribute past gains when repricing the policies, when defining the current interest to be credited, or when determining mortality, morbidity or expenses to be charged.
- (3) Increase the interest credited to present a more competitive rate while at the same time increasing the mortality, morbidity, expense or other charge or to adjust these and other rates in a similar manner, unless justified by actual company experience.
- (4) Review less than all pricing assumptions at repricing or setting of the current credits and charges, thereby upsetting the consistent and equitable treatment of the policyholders.
- (5) Add additional pricing variables to the definition of a class of insureds after issue, without the prior written approval of the commissioner.

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

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

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

(9) Have one class of insureds support, or be supported by, another class.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-100, filed 12/20/85.]

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

(2) For substandard issues, the commissioner must be supplied with a sample of the appropriate policy pages completed through each type of rating used by the company; for example, percentage of standard class premium, extra premium, temporary or permanent flat charge per thousand.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-110, filed 12/20/85.]

Chapter 284-87 WAC

JOINT UNDERWRITING ASSOCIATION FOR MIDWIFERY AND BIRTHING CENTERS MALPRACTICE INSURANCE

WAC

284-87-010	Purpose.
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284-87-160	Additional notice required.
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WAC 284-87-010 Purpose. The purpose of this chapter is to establish a joint underwriting association pursuant to chapter 48.87 RCW, to provide midwifery and birth center malpractice insurance.

[Statutory Authority: RCW 48.02.060 and 48.87.100, 94-02-053 (Order R 93-18), § 284-87-010, filed 12/30/93, effective 1/30/94.]

WAC 284-87-020 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Association" means the joint underwriting association established pursuant to the provisions of chapter 48.87 RCW.

"Board" means the governing board of the association.

"Licensee" means any person or birth center facility licensed to provide midwifery services pursuant to chapters 18.46, 18.50, and 18.88 RCW.

"Market assistance plan" or "MAP" means the voluntary consumer assistance plan established pursuant to the provisions of RCW 48.22.050.

"Member insurer" means any insurer that on or after July 25, 1993, possesses a certificate of authority to write medical malpractice, general casualty insurance, or both, within this state.

"Midwifery and birth center insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of negligence or malpractice in rendering professional service by any licensee.

"Service insurer" means any insurance company designated by the association and approved by the commissioner to issue policies pursuant to this chapter.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-020, filed 12/30/93, effective 1/30/94.]

WAC 284-87-030 The association. (1) A nonprofit joint underwriting association for midwifery and birthing centers malpractice insurance is hereby established. Membership in the association shall be mandatory for all insurers that on or after July 25, 1993, possess a certificate of authority to write medical malpractice, general casualty insurance, or both, within this state. Every such insurer shall be and remain a member of the association and fulfill all its membership obligations as a condition of its authority to continue to transact property and casualty insurance business in this state. An insurer ceases to be a member insurer upon surrender of its certificate of authority to transact insurance in this state.

(2) The association shall remain inactive, except for the actions of the board enumerated in WAC 284-78-050 through 284-78-080, until it is activated by the commissioner as provided in WAC 284-78-040.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-030, filed 12/30/93, effective 1/30/94.]

WAC 284-87-040 Activation of association. (1) If the commissioner finds that any licensee is not reasonably able to obtain midwifery or birthing center malpractice insurance with liability limits of at least one million dollars per claim and three million dollars per annual aggregate, or such other minimum level of mandated coverage as determined by the department of health, from the voluntary insurance market, the commissioner may notify the association of such finding and direct that its board promptly convene and submit its plan of operation and bylaws to the commissioner for approval. Such plan shall include its evaluation and report relative to the feasibility of a market assistance plan to be conducted by the association as a voluntary program, or a plan to be conducted pursuant to the authority given to the commissioner by RCW 48.22.050. Pursuant to RCW 48.87.030, a MAP shall be used prior to activating a joint underwriting association.

(2) If the use of a MAP is unsuccessful, the commissioner may instruct the board to activate the authority of the association and commence writing midwifery and birthing center malpractice insurance, in accordance with this chapter.

[Statutory Authority: RCW 48.02.060, 48.87.100 and 48.87.050. 94-13-006 (Order R 94-11), § 284-87-040, filed 6/2/94, effective 7/3/94. Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-040, filed 12/30/93, effective 1/30/94.]

WAC 284-87-050 Administration. (1) The association shall be administered by a governing board, subject to the supervision of the commissioner, and operated by a manager appointed by the board.

(2) The board shall consist of seven members. Four board members shall be member insurers appointed by the commissioner. A fifth board member shall be the insurer designated as the service insurer for the association (or, if there is more than one service insurer, the fifth board member shall be such service insurer as the commissioner designates as the board member). The other two board members shall be licensees who are appointed by the commissioner to so serve, neither of whom shall be interested, directly or indirectly, in any insurer except as a policyholder. Three of the original board members shall be appointed to serve an initial term of three years, two shall be appointed to serve an initial term of two years, and the remaining shall be appointed to serve a one-year initial term. All other terms shall be for three years or until a successor has been appointed. Not more than one member insurer in a group under the same management or ownership shall serve on the board at the same time. At least one of the four insurers on the board shall be a domestic insurer. Members of the board may be removed by the commissioner for cause.

(3) Each person serving on the board or any subcommittee thereof, each member insurer of the association, and each officer and employee of the association shall be indemnified by the association against all costs and expenses actually and necessarily incurred by him, her, or it in connection with the defense of any action, suit, or proceeding in which he, she, or it is made a party by reason of his, her, or its being or having been a member of the board, or a member or officer or employee of the association, except in relation to matters as to which he, she, or it has been judged in such action, suit, or proceeding to be liable by reason of wilful misconduct in the performance of his, her, or its duties as a member of such board, or member, officer, or employee of the association. This indemnification shall not be exclusive of other rights as to which such member, or officer, or employee may be entitled as a matter of law.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-050, filed 12/30/93, effective 1/30/94.]

WAC 284-87-060 General powers and duties of the board. (1) Within thirty days after the appointment of its members by the commissioner, the board shall prepare and adopt a plan of operation and bylaws consistent with this chapter, subject to approval by the commissioner. In a timely manner thereafter, the board shall take all actions necessary to prepare the association to receive applications and issue policies, when and if the commissioner activates

the association as provided in WAC 284-87-040. These actions shall include the preparation of all necessary policy forms and rating information to be filed with the commissioner for approval and all necessary operating manuals and procedures to be followed.

(2) The board shall meet as often as may be required to perform the general duties of the administration of the association or on the call of the commissioner. Four members of the board shall constitute a quorum at least one of whom shall be a licensee board member.

(3) The board may appoint a manager, who shall serve at the pleasure of the board, to perform any duties necessary or incidental to the proper administration of the association, including the hiring of necessary staff.

(4) The board shall annually furnish to all member insurers of the association and to the commissioner a written report of operations.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-060, filed 12/30/93, effective 1/30/94.]

WAC 284-87-070 Assessments. (1) The board may calculate, levy, and collect assessments from member insurers whenever necessary for the orderly operation of the association.

(2) After its formation, the board may calculate, levy, and collect from member insurers a start-up assessment to pay initial expenses of the association and to establish any necessary reserves. The start-up assessment shall not exceed five hundred dollars per member insurer. For ease of administration, the share of the start-up assessment levied upon and collected from each member insurer shall be the same for each member insurer, regardless of size and regardless of whether it is actively writing business in this state.

(3) Any assessment subsequent to the initial start-up assessment shall be used to offset losses and/or expenses in excess of income received by the association. These assessments may be made as often as the board determines is necessary. Each member insurer shall be assessed a proportionate share based on the sum of "direct premiums earned" in this state on the reporting line for "medical malpractice" and for "other liability" (currently lines 11 and 17, of page 14), on the member insurer's most recent annual statement to the commissioner. Member insurers reporting zero "direct premiums earned" on the member insurer's most recent annual statement to the commissioner, will not be assessed.

(4) Assessments are due thirty days after mailing. Any member insurer failing to remit its assessment when due is subject to revocation of its certificate of authority.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-070, filed 12/30/93, effective 1/30/94.]

WAC 284-87-080 Statistics, records, and reports.

(1) The association shall maintain statistics on business written and shall make the following quarterly report to the commissioner:

(a) Number of applications received by the association;

(b) Number of applications accepted by the association and the total and average premiums charged, including the high and low premiums;

(c) Number of risks declined;

(d) Number of risks conditionally declined and the number ultimately accepted after having been conditionally declined; and

(e) Number of risks cancelled.

(2) In addition to statistics, the association shall maintain complete and separate records of all business transactions, including copies of all policies and endorsements issued by the association, and records of reasons provided for each declination of coverage or cancellation of coverage, including the results of any on-site inspections, or investigations of applicants or insureds or their employees. Information concerning individual licensees shall be kept confidential to the extent permitted by law.

(3) Regular reports of the association's operations shall be submitted to all members of the board and to the commissioner, such reports to include, but not necessarily to be limited to, premiums written and earned, losses, including loss adjustment expense, paid and incurred, all other expenses incurred, outstanding liabilities, and, at least once a year, the proposed annual budget of the association for the next fiscal year.

(4) The books of account, records, reports, and other documents of the associations shall be open to the commissioner for examination at all reasonable times.

(5) The books of account, records, reports, and other documents of the association shall be open to inspection by members only at such times and under such conditions as the board shall determine.

(6) The books of account of any and all servicing insurers may be audited by a firm of independent auditors designated by the board.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-080, filed 12/30/93, effective 1/30/94.]

WAC 284-87-090 Eligibility of licensees for coverage. Any licensee that is unable to obtain midwifery or birthing center insurance with liability limits of at least one million dollars per claim and three million dollars per annual aggregate, or such other minimum level of mandated coverage as determined by the department of health, from the voluntary insurance market or from any market assistance plan organized pursuant to RCW 48.22.050, is eligible to apply for coverage through the association. The association's service insurer shall promptly process such application and, if the licensee is judged to be an acceptable insurable risk, offer coverage to the licensee. In view of the purpose of chapter 48.87 RCW, every licensee will be presumed to be an acceptable insurable risk for the association. To refuse coverage to any licensee meeting the other eligibility requirements of this section, the association must have the prior written approval of the commissioner. The commissioner will grant such approval only if the association demonstrates that extraordinary circumstances justify refusing coverage to such individual licensee.

[Statutory Authority: RCW 48.02.060, 48.87.100 and 48.87.050. 94-13-006 (Order R 94-11), § 284-87-090, filed 6/2/94, effective 7/3/94. Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-090, filed 12/30/93, effective 1/30/94.]

WAC 284-87-100 Standard policy coverage—Premiums. (1) All policies issued by the association shall have liability limits of at least one million dollars per claim and three million dollars per annual aggregate, or such other minimum level of mandated coverage as determined by the department of health, and shall be issued for a term of one year.

(2) Premiums shall be based on the association's rate filings approved by the commissioner in accordance with chapter 48.19 RCW. Such rate filings shall provide for modification of rates for licensees according to the type, size, and past loss experience of each licensee, and any other differences among licensees that can be demonstrated to have a probable effect upon losses.

(3) Consistent with the nonprofit character of the association, rates for policies issued by the association shall be set so that the expected profit (that is, premiums plus investment income minus the sum of expenses and losses) is zero.

(4) The association is exempt from the requirements of WAC 284-24-065.

[Statutory Authority: RCW 48.02.060, 48.87.100 and 48.87.050. 94-13-006 (Order R 94-11), § 284-87-100, filed 6/2/94, effective 7/3/94. Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-100, filed 12/30/93, effective 1/30/94.]

WAC 284-87-110 Renewal of policies. (1) Policies written by the association will not automatically renew. To obtain continuing coverage by the association, a licensee must again satisfy initial eligibility requirements under WAC 284-87-090 at the end of the expiring policy term.

(2) The association shall notify covered licensees in writing at least forty-five days prior to the expiration of a policy term of the need to submit a new application for coverage to the association to continue coverage.

(3) If the association fails to provide the required written notice, the existing policy shall continue in force until the association has provided the required notice. In such case, premium shall be charged the licensee on a pro rata basis for coverage during the extended coverage period.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-110, filed 12/30/93, effective 1/30/94.]

WAC 284-87-120 Cancellation of policies. (1) No policy or binder issued pursuant to this chapter shall be cancelled except:

(a) For nonpayment of premium, in which case cancellation of the policy shall be effected by providing ten days written notice in advance of the date of cancellation. Payment to the association of all premiums due, prior to the effective date of the cancellation, shall continue coverage as if no cancellation notice had been issued; or

(b) With the prior written approval of the commissioner upon the request of the board, for cause which would have been grounds for refusal of coverage under WAC 284-87-090.

(2) Notice of cancellation, accompanied by the actual reason therefor, shall be sent to the named insured.

(3) Any cancellation notice sent to the named insured shall be accompanied by a statement that the named insured has a right of appeal to the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-120, filed 12/30/93, effective 1/30/94.]

WAC 284-87-130 Right of appeal. (1) Any applicant or insured, licensed pursuant to chapter 18.46, 18.50, or 18.88 RCW, shall have a right of appeal to the commissioner, including the right to appear personally before the commissioner or his or her designee, if requested by the person seeking appeal, from any decision by the board.

(2) Appeals to the commissioner under this provision shall be handled in accordance with chapters 48.04 and 34.05 RCW.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-130, filed 12/30/93, effective 1/30/94.]

WAC 284-87-140 Cooperation of agents and brokers. All licensed insurance agents and brokers shall provide full cooperation in carrying out the aims and the operation of the association.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-140, filed 12/30/93, effective 1/30/94.]

WAC 284-87-150 Commissions. The association shall pay commissions as established by the board on policies issued pursuant to this chapter to the licensed agent or broker designated by the applicant.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-150, filed 12/30/93, effective 1/30/94.]

WAC 284-87-160 Additional notice required. Any notice of cancellation or nonrenewal of midwifery or birthing center insurance given by an insurer to a licensee potentially eligible for coverage through the association shall include or be accompanied by an explanation of the licensee's right and procedure to obtain insurance through the association.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-160, filed 12/30/93, effective 1/30/94.]

WAC 284-87-170 Termination of association. The association shall have perpetual existence, subject to repeal or modification of this chapter.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 94-02-053 (Order R 93-18), § 284-87-170, filed 12/30/93, effective 1/30/94.]

Chapter 284-90 WAC RULES PERTAINING TO AIDS

WAC

284-90-010	Purpose.
284-90-020	Insuring procedures relating to AIDS.
284-90-030	Policy reserves—Annual financial statements.

WAC 284-90-010 Purpose. (1) The purpose of this chapter is to assure nondiscriminatory treatment of insureds and prospective insureds by establishing minimum standards insurers must meet with respect to acquired immune deficiency syndrome (AIDS) and its related conditions. Such related conditions include a positive testing for the Human T-Cell Lymphotropic Virus Type III (HTLV-III) antibodies and a diagnosis of AIDS related complex.

(2) The insurance code prohibits unfair discrimination between insureds having like risk and exposure factors. The practical effect of the law is to require grouping of insureds into classes of like risk and exposure and charging a premium commensurate with the risk and exposure. This assures the equitable treatment of each class of insureds in the sense that the premium charge is reasonably related to the risk assumed by the insurer and that no class of insureds supports (or is supported by) another class of insureds. For example: Insureds with a heart condition should not subsidize (or be subsidized by) insureds with AIDS or diabetes; policies issued on a standard basis should not be surcharged to support those issued to insureds suffering from an ailment. To properly classify such prospective insureds, insurers must ask appropriate questions on application forms and may require reasonable testing of prospective insureds.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-010, filed 10/15/86.]

WAC 284-90-020 Insuring procedures relating to AIDS. (1) AIDS and its related conditions are diseases and must be considered as such under the insurance laws of this state. Underwriting considerations must be consistent with the underwriting considerations applied to other diseases. Prospective insureds must be accepted or rejected or rated standard or substandard on the basis of bona fide and substantiated statistical differences in risk or exposure.

(2) Questions about AIDS and related health conditions on applications for insurance must be in clear and understandable language and must lend themselves to the placement of applicants in the proper class of insureds. Questions which are ambiguous or misleading are prohibited.

(3) When used, the blood testing of insurance applicants must be administered on a nondiscriminatory basis. If a prospective insured is to be declined or rated substandard because of HTLV-III antibodies in the blood, such action must be based on a Western Blot Test or another test of equal or greater accuracy. Testing procedures of lesser accuracy may be used on a nondiscriminatory basis for underwriting purposes, but a prospective insured may not be declined or rated substandard solely on the basis of results from such test(s).

(4) There are several aspects of the disease AIDS which may create unforeseen claim settlement problems under life insurance, loss of time, and medical coverages. The likelihood of the claimant incurring medical expenses from several different symptoms of AIDS or one of its related conditions may make it difficult to determine when the disease first manifested itself. The long incubation period along with the concurrent and aggravating ailments may create problems with the application of the preexisting conditions clause and the incontestable provision, as well as the rules which determine a new spell of illness. The benefit provision, including any extended benefit provision, will determine the extent of claim payments if the disease manifested itself while the policy was in force but continued after expiration of coverage or termination of the contract. Such matters, and others unique to the disease of AIDS and its related conditions, must be resolved in a manner consistent with the settlement of claims resulting from other diseases.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-020, filed 10/15/86.]

WAC 284-90-030 Policy reserves—Annual financial statements. The instructions for the annual statement of life and disability insurers, health care service contractors, and health maintenance organizations which must be filed with the insurance commissioner require an actuarial statement setting forth the actuary's opinion relating to policy reserves and other actuarial items. Effective with statements submitted after December 31, 1986, such statements shall take into account the effect on the adequacy of the insurer's reserves of AIDS and its related conditions and any other disease that does or may potentially constitute an epidemic.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-21-065 (Order R 86-5), § 284-90-030, filed 10/15/86.]

Chapter 284-91 WAC

HEALTH INSURANCE ACCESS REGULATION

WAC

284-91-010	Board of directors.
284-91-020	Organizational meeting, duties of board of directors.
284-91-025	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.
284-91-050	Involuntary terminations for other than nonpayment of premiums.

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 determi-

nation 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 approved: *Provided However*, That if the plan of operation of the pool or any policy issued by the pool contains any condition or provision that does not conform to the requirements of chapter 48.41 RCW or this chapter, the plan of operation or any policy issued by the pool shall be construed and applied in accordance with such conditions and provisions as would have applied had the plan of operation or policy issued by the pool been in full compliance with chapter 48.41 RCW and this chapter.

[Statutory Authority: RCW 48.02.060 and 48.41.170. 91-16-052 (Order R 91-4), § 284-91-025, filed 8/1/91, effective 9/1/91. 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)
COVERAGES	Earned <u>Premium</u>	Incurred <u>Claims</u>	Expense <u>Charges</u>	Surplus <u>(Deficit)</u>	Incurred Loss Ratio <u>(2) ÷ (1)</u>	Expense Ratio <u>(3) ÷ (1)</u>	Combined Ratio <u>(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

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(2) PLAN A - DEPENDENT INSUREDS
 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	_____	_____	_____	_____	_____	_____	_____

(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	_____	_____	_____	_____	_____	_____	_____

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(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.]

284-92-480 Reports.
284-92-490 Required disclosure "notice."
284-92-500 Domestic risk retention groups—Formation.
284-92-510 Domestic risk retention groups—Reports.

WAC 284-91-050 Involuntary terminations for other than nonpayment of premiums. (1) For purposes of RCW 48.41.100, coverage under prior health insurance shall be deemed to have been involuntarily terminated for a reason other than nonpayment of premium, except where the insured person voluntarily ceased paying required premiums while otherwise eligible to continue such prior coverage. Therefore, as an example, loss of eligibility for group health insurance because of voluntary termination of employment by a person covered by an employer's group health insurance policy will not be deemed voluntary termination of the prior insurance coverage.

(2) For purposes of RCW 48.41.140(3), coverage under any prior health insurance will be deemed to have been involuntarily terminated for a reason other than nonpayment of premium, if the premium required to continue coverage under such insurance exceeds by one-third or more the

premium required to cover the individual under the pool's one thousand dollar deductible plan.

[Statutory Authority: RCW 48.02.060 and 48.41.170. 91-16-052 (Order R 91-4), § 284-91-050, filed 8/1/91, effective 9/1/91.]

**Chapter 284-92 WAC
LIABILITY RISK RETENTION**

WAC

GENERAL

284-92-010 Definitions.
284-92-020 Preexisting registrations.

PURCHASING GROUPS

284-92-210 Registration required.
284-92-220 Registration effective upon notice by commissioner.
284-92-230 Appointment for service of process.
284-92-240 Suspension and revocation of registration.
284-92-250 Insurers and agents.
284-92-260 Forms.
284-92-270 Disclosure that there is no guaranty association coverage and that some laws may not apply.
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RISK RETENTION GROUPS

284-92-410 Registration required.
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284-92-430 Registration—Appointment for service of process.
284-92-440 Suspension and revocation of registration.
284-92-450 Agents.
284-92-460 Tax.
284-92-470 Notice of changes.

GENERAL

WAC 284-92-010 Definitions. The definitions in chapter 48.92 RCW apply in this regulation unless otherwise specified or unless the context clearly requires otherwise.

(1) "Domestic purchasing group" means a purchasing group formed under the laws of this state.

(2) "Domestic risk retention group" means a risk retention group formed under the laws of this state.

(3) "State" includes any state of the United States or the District of Columbia.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-010, filed 9/1/93, effective 10/2/93.]

WAC 284-92-020 Preexisting registrations. Registrations of purchasing groups effected before the date this regulation becomes effective are cancelled as of 11:59 p.m. on December 31, 1993. This date may be extended by the commissioner in a particular case or class of cases for good cause shown. After that date, or after the extended date, no purchasing group is registered unless registered after the effective date of this regulation.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-020, filed 9/1/93, effective 10/2/93.]

PURCHASING GROUPS

WAC 284-92-210 Registration required. No purchasing group may provide insurance, offer to provide insurance, or solicit or invite applications for insurance, as to Washington residents, or otherwise transact insurance in Washington or with respect to Washington residents, until it is registered.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-210, filed 9/1/93, effective 10/2/93.]

WAC 284-92-220 Registration effective upon notice by commissioner. No purchasing group is registered until it has been notified by the commissioner that it is registered. There is no "deemer."

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-220, filed 9/1/93, effective 10/2/93.]

WAC 284-92-230 Appointment for service of process. (1) Except as provided by RCW 48.92.080, the request for registration must include an appointment of the commissioner as agent for service of process, as provided in chapter 48.92 RCW.

(2) The doing of business as a purchasing group in Washington, or as to Washington residents, in itself constitutes such an appointment of the commissioner. This automatic appointment is effective whether or not an explicit appointment was made or was valid or effective. This automatic appointment does not apply to a purchasing group not required so to appoint the commissioner under RCW 48.92.080.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-230, filed 9/1/93, effective 10/2/93.]

WAC 284-92-240 Suspension and revocation of registration. The grounds for suspension or revocation mentioned in this section are in addition to those mentioned elsewhere in this regulation or in other applicable law or regulation. The registration of a purchasing group may be suspended or revoked:

(1) If any basis exists on which, if the purchasing group were an insurer, agent, or broker, its certificate of authority or its license could be suspended or revoked.

(2) If any insurer issuing policies for the purchasing group is subject, or would be subject if it were an authorized insurer, to suspension or revocation of its certificate of authority under RCW 48.05.140.

(3) If any insurer issuing policies for or to the purchasing group has any order of supervision, receivership, conservation, or liquidation, or any order similar to such an order, entered against it in any state or country by a court or insurance commissioner (or equivalent supervisory official).

(4) If the purchasing group solicits or accepts, or permits the solicitation or acceptance, of insurance applications by a person not licensed in Washington as an insurance agent or broker; or does or permits any other act, by a person not licensed as an agent or broker, if that act may be performed only by one so licensed.

(5) If the purchasing group fails to reply fully, accurately, and in writing to an inquiry of the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-240, filed 9/1/93, effective 10/2/93.]

WAC 284-92-250 Insurers and agents. (1) Insurance for a purchasing group may be provided only by one or more of the following: An insurer holding a certificate of authority to transact the relevant line of business in Washington; a risk retention group registered in Washington; or an insurer acting lawfully in accordance with chapter 48.15 RCW and the regulations thereunder (except as provided in chapter 48.92 RCW or this regulation). Insurance for a domestic purchasing group may be provided only by an insurer holding a Washington certificate of authority to transact that type of insurance.

(2) Chapters 48.15 and 48.17 RCW require that certain acts and functions be performed only by a person licensed thereunder. Those requirements apply equally to transactions involving purchasing groups, except as provided in RCW 48.92.120(3) and WAC 284-15-100.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-250, filed 9/1/93, effective 10/2/93.]

WAC 284-92-260 Forms. (1) The requirements for filing and approval of policy rates and forms apply to forms

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issued to or in connection with purchasing groups to the same extent as they apply in other situations.

(2) Notwithstanding subsection (1) of this section, forms that have been properly issued in Washington before the effective date of this regulation may continue to be issued or renewed until February 1, 1994, or such later date as the commissioner approves. After that date, those forms are subject to subsection (1) of this section.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-260, filed 9/1/93, effective 10/2/93.]

WAC 284-92-270 Disclosure that there is no guaranty association coverage and that some laws may not apply. (1) Under RCW 48.92.050 (3) and (4), in some situations there is no coverage by the Washington Insurance Guaranty Association for some insurance obtained by a purchasing group. Under RCW 48.92.090(2), the purchasing group must inform its members of the lack of that protection and that the insurer or risk retention group may not be subject to all insurance laws and regulations of this state. In any such situation, the disclosure must be in writing. It must be given when the application is taken. The disclosure must be reasonably calculated to make the individual aware of the lack of guaranty coverage and the inapplicability of some laws and regulations. The lack of coverage and that inapplicability may not be presented as an advantage or as a technical oddity, nor may it be downplayed by references to the solvency of the insurer or otherwise.

(2) If the insurance is to be issued by a risk retention group, compliance with WAC 284-92-700 and RCW 48.92.040(7) is sufficient compliance with this rule and with RCW 48.92.090(2).

(3) The insurer, for a domestic purchasing group on risks located in Washington, must be an insurer holding a Washington certificate of authority for that type of insurance, or a registered risk retention group.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-270, filed 9/1/93, effective 10/2/93.]

WAC 284-92-280 Notice of changes. If any information included in the request for registration, or otherwise provided to the commissioner, changes or is found to have been incorrect when submitted, the commissioner must be notified within ten days of the change or the discovery of the inaccuracy.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-280, filed 9/1/93, effective 10/2/93.]

WAC 284-92-290 Domestic purchasing groups. (1) No domestic purchasing group will be registered unless the purchasing group has and maintains in Washington the records applicable to its business, including records as to insured persons, financial matters, and the like. There must also be resident in Washington an officer of the purchasing group who is able and qualified to present, interpret, and explain those records to the commissioner or the commissioner's representative on demand.

(2) Each domestic purchasing group shall submit an annual report to the commissioner. That report shall state the number of policies, amount of insurance coverage, and amount of premium provided, the number and types of

insured persons, and such other matters as the commissioner shall direct. The report shall be submitted for each calendar year, and shall be submitted no later than January 31 of the following year unless the commissioner allows a later filing. Any other information requested by the commissioner shall be promptly provided.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-290, filed 9/1/93, effective 10/2/93.]

RISK RETENTION GROUPS

WAC 284-92-410 Registration required. No risk retention group may provide insurance, offer to provide insurance, or solicit or invite applications for insurance, as to Washington residents, or otherwise transact insurance in Washington or with respect to Washington residents, until it is registered.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-410, filed 9/1/93, effective 10/2/93.]

WAC 284-92-420 Registration effective upon notice by commissioner. No risk retention group is registered until it has been notified by the Commissioner that it is registered. There is no "deemer."

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-420, filed 9/1/93, effective 10/2/93.]

WAC 284-92-430 Registration—Appointment for service of process. (1) The request for registration must include an appointment of the commissioner as agent for service of process, as provided in chapter 48.92 RCW.

(2) The doing of business as a risk retention group in Washington, or as to Washington residents, in itself constitutes such an appointment of the commissioner. This automatic appointment operates in all cases, whether or not an explicit appointment was made or was valid or effective.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-430, filed 9/1/93, effective 10/2/93.]

WAC 284-92-440 Suspension and revocation of registration. The grounds for suspension or revocation mentioned in this section are in addition to those mentioned elsewhere in this regulation or in other applicable law or regulation. In addition, a domestic risk retention group is subject to the same sanctions, on the same grounds, as a domestic insurer, including revocation of its certificate of authority. The registration of a risk retention group may be suspended or revoked if:

(1) Any basis exists on which, if the risk retention group were an authorized insurer, its certificate of authority could be suspended or revoked, under chapter 48.05 RCW or otherwise.

(2) If the risk retention group has any order of supervision, receivership, conservation, or liquidation, or any order similar to such an order, entered against it in any state or country by a court or insurance commissioner (or equivalent supervisory official); or any such court or official finds that the risk retention group is in a hazardous financial or financially impaired condition.

(3) If the risk retention group solicits or accepts, or permits the solicitation or acceptance, of insurance applications by anyone not appropriately licensed as an agent or broker; or does or permits any other act by a person not appropriately licensed as an agent or broker, if that act may be performed only by one so licensed.

(4) An order is entered by a court enjoining the risk retention group from soliciting or selling insurance, or operating.

(5) If the risk retention group fails to respond fully, accurately, and in writing to an inquiry of the commissioner.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-440, filed 9/1/93, effective 10/2/93.]

WAC 284-92-450 Agents. Only appropriately licensed agents or brokers may solicit or accept applications for insurance to be issued by a risk retention group.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-450, filed 9/1/93, effective 10/2/93.]

WAC 284-92-460 Tax. The premium tax under chapter 48.14 applies to insurance issued by risk retention groups. Failure to pay the tax when due is grounds for suspension or revocation of the registration of the risk retention group, in addition to other fines, penalties, interest, and other consequences provided by law or regulation.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-460, filed 9/1/93, effective 10/2/93.]

WAC 284-92-470 Notice of changes. If any information included in the request for registration, or otherwise provided to the commissioner, changes or is found to have been incorrect when submitted, the commissioner must be notified within ten days of the change or the discovery of the inaccuracy.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-470, filed 9/1/93, effective 10/2/93.]

WAC 284-92-480 Reports. Each registered risk retention group shall submit to the commissioner copies of any annual statements or reports, or other reports on operations and financial results or condition, that are filed by it with the insurance regulatory official of its state of domicile or with the National Association of Insurance Commissioners. Quarterly and other reports are not required and should not be submitted unless requested by the commissioner. See WAC 284-92-710 as to reports required of domestic risk retention groups. Reports shall be on disk as well as in paper form. These reports are in addition to those required by RCW 48.92.030(2).

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-480, filed 9/1/93, effective 10/2/93.]

WAC 284-92-490 Required disclosure "notice." The "notice" requirement of RCW 48.92.040(7) is to be applied as follows:

(1) On an application form, the notice must appear on the first page. On a policy, the notice must appear both on the first page and on the declaration page; if the declaration page is the first page, one appearance of the notice suffices.

(2) The notice or a similar disclosure may be repeated elsewhere.

(3) The disclosure and the information in it may not be presented as an advantage or as a technical oddity, nor downplayed by references to the solvency of the insurer or otherwise.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-490, filed 9/1/93, effective 10/2/93.]

WAC 284-92-500 Domestic risk retention groups—Formation. A domestic risk retention group must be formed in compliance with chapter 48.06 RCW. It must meet the capital and surplus requirements applicable under RCW 48.05.340 to insurers transacting the kind or kinds of insurance that the domestic risk retention group proposes to transact. It must comply with the other requirements for domestic insurers and with chapter 48.92 RCW.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-500, filed 9/1/93, effective 10/2/93.]

WAC 284-92-510 Domestic risk retention groups—Reports. Domestic risk retention groups shall file the reports required by RCW 48.92.030. In addition, domestic risk retention groups shall file quarterly financial reports and any other statements or reports required by the commissioner for such groups in general or for any one or more such groups. The commissioner may require any reports from any one or more risk retention groups, at any time and from time to time. Reports shall be both on paper and on diskette.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 93-19-006 (Order R 93-10), § 284-92-510, filed 9/1/93, effective 10/2/93.]

Chapter 284-95 WAC

TRANSFER OF INSURANCE CONTRACTS

WAC

284-95-010	Title.
284-95-020	Purpose and scope.
284-95-030	Definitions, applications, and procedures.
284-95-040	Notice requirements.
284-95-050	Requirement of full disclosure.
284-95-060	Prohibited policy provisions.
284-95-070	Transfers to unauthorized insurers.
284-95-080	Unfair or deceptive acts or practices.

WAC 284-95-010 Title. This regulation, WAC 284-95-010 through 284-95-060, inclusive, shall be known and may be cited as "the Washington regulation on transfer of insurance contracts."

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-010, filed 11/18/91, effective 12/19/91.]

WAC 284-95-020 Purpose and scope. (1) This regulation establishes procedures to be followed with respect to the transfer of insurance contracts from a transferring company to an assuming company, establishes notice and disclosure requirements to protect the rights of policyowners, and defines unfair or deceptive acts and practices and unfair methods of competition in the conduct of the business of insurance, pursuant to RCW 48.30.010.

(2) This regulation applies to any transfer of insurance contracts from a transferring company to an assuming company where:

(a) The policyowner, as defined in WAC 284-95-030(5), is a resident of this state at the time of the proposed transfer; or

(b) The holder of a certificate of group insurance is a resident of this state at the time of the proposed transfer and meets the criteria set forth in WAC 284-95-030(5).

(3) This regulation shall not apply in the following situations:

(a) Mergers or consolidations;

(b) A transferring company subject to an order of rehabilitation, conservation, liquidation, or similar applicable order issued in this or any other jurisdiction;

(c) Withdrawal from the state by a transferring company, pursuant to RCW 48.05.290;

(d) The absorption of a subsidiary insurance company by a parent company, where the parent company absorbs the entire subsidiary insurance company through a merger. However, this regulation shall apply where the parent company acquires only the insurance contracts of the subsidiary insurance company.

(4) Unless the transferring company complies fully with the requirements of this regulation, it shall be deemed to remain liable for its obligations to the policyowners under its insurance contracts.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-020, filed 11/18/91, effective 12/19/91.]

WAC 284-95-030 Definitions, applications, and procedures. (1) "A transfer of insurance contracts" means a transaction in which a transferring company, as defined in subsection (3) of this section, transfers one or more insurance contracts, together with all or substantially all of the liabilities and obligations under any such insurance contracts, to an assuming company, as defined in subsection (4) of this section, so that the rights of policyowners under the contracts are directly affected. This includes a transfer of the type deceptively known as "assumption reinsurance." This regulation is not intended to apply to a case of true reinsurance, where an insurer obtains additional security for the original undertaking.

(2) "Consent to transfer," in the context of this regulation, means the active and affirmative consent of each policyowner, as defined in subsection (5) of this section. This consent must be in writing, signed by the policyowner. It will not be presumed. It must be made after sufficient notice and disclosure concerning the proposed transfer, and concerning both the transferring company and the assuming company, as more fully set forth in WAC 284-95-040 and 284-95-050. Where a group insurance contract is concerned, the consent required is that of the group policyowner. Where the holder of a certificate of group insurance meets the criteria set forth in subsection (5) of this section, then the certificate holder is the policyowner, for the purpose of obtaining consent.

(3) "Transferring company" means the insurance company, fraternal benefit society, health care service contractor, or health maintenance organization which proposes to transfer one or more insurance contracts,

together with all or substantially all of the liabilities arising under any such insurance contract, to an assuming company.

(4) "Assuming company" means the insurance company, fraternal benefit society, health care service contractor, or health maintenance organization which proposes to acquire one or more insurance contracts, together with all or substantially all of the liabilities arising under any such insurance contracts or contracts, from a transferring company.

(5) "Policyowner" means any individual or entity which has the right to either agree or not agree to alter the terms of an insurance contract and includes any person issued a certificate under a group insurance contract if such contract vests in that person rights that the owner of the group contract may not terminate.

(6) "An insurance contract," for purposes of this regulation, includes a life or disability insurance policy, an annuity contract, and a contract issued by a health care service contractor or health maintenance organization.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-030, filed 11/18/91, effective 12/19/91.]

WAC 284-95-040 Notice requirements. (1) The transferring company shall provide to each policyowner at least thirty days advance written notice of its intent to transfer the insurance contract to an assuming company. The written notice shall be deposited in the United States mail, postage prepaid, addressed to the last known address for the policyowner.

(2) The transferring company shall keep records of all notices which are returned as undeliverable and also of all responses which are signed and returned by the policyowner, regardless of whether those responses are consents or refusals to consent.

(3) The transferring company shall provide advance notice of the proposed transfer to the commissioner, which shall include a complete set of the forms and materials to be sent to policyowners. The notice shall be sent at least thirty days before it is sent to the policyowner.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-040, filed 11/18/91, effective 12/19/91.]

WAC 284-95-050 Requirement of full disclosure. (1) At a minimum, the notice sent to the policyowner shall state the following in language easily understood by a policyowner:

(a) The date upon which the transfer of liabilities arising under the insurance contract is to take place.

(b) The name and address of the proposed assuming company.

(c) The fact that the policyowner has a legal right to either consent to the proposed transfer, or to refuse to consent to it.

(d) The fact that if the policyowner wishes to accept the proposed transfer, that person must affirmatively do so by signing and returning the enclosed consent form.

(e) The fact that unless the policyowner signs and returns the enclosed consent form, the proposed transfer will not take place as to the insurance contract in his or her case, and that as a result the liabilities arising under that insurance contract will remain with the transferring company.

(f) Depending upon the intent of the transferring company, the policyowner should be told whether the transferring company will or may utilize the services of the proposed assuming company or another entity for administratively servicing the insurance contract, if consent to the transfer is not given, even though the obligations and liabilities under the insurance contract will remain with the transferring company. Examples of such servicing should be illustrated.

(g) The reason or reasons for the proposed transfer.

(h) Enough information about both the transferring company and the assuming company for the policyowner to make an informed choice about whether to consent to the proposed transfer or not. Necessary information will vary from one situation to another. However, it shall include, although it is not limited to, the following: The assets and liabilities of each company, and the business experience of each, particularly with respect to the kind of insurance involved in the proposed transfer.

(i) Whether the assuming company holds a valid certificate of authority or registration for the kind of insurance involved in the proposed transfer, issued by the state of which the policyowner is a resident.

(j) Whether the proposed transfer would have any effect upon availability and extent of protection afforded by any state guaranty fund, in the event of insolvency of the proposed assuming company.

(2) The notice and disclosure shall be accompanied by a form by which the policyowner may consent to or reject the proposed transfer. The form shall be worded in language easily understood by the policyowner, and be accompanied by a postage prepaid return envelope, by which it may be returned. All the forms shall be subject to the type size requirements of RCW 48.20.012(2).

(3) After processing, the transferring company shall return to consenting policyowners a copy of the consent to transfer for attachment to the insurance contract. The transferring company shall retain the policyowner's written consent with its records pertaining to each insurance contract.

(4) The notice and disclosure documents must also advise the policyowner that the transferring company will not unfairly discriminate against those policyowners who do not consent to the transfer.

(5) A certificate of assumption shall be provided to each consenting policyowner. The certificate shall include, at a minimum, the statement that the assuming company assumes all contractual obligations under the insurance contract. It shall include the name of the assuming company and its address to which communications relating to the insurance contract should be sent. The certificate of assumption shall become a part of the transferred contract. The form of certificate of assumption shall be filed with the insurance commissioner pursuant to RCW 48.18.100.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-050, filed 11/18/91, effective 12/19/91.]

WAC 284-95-060 Prohibited policy provisions. No insurance contract, or other contractual document pertaining to any such insurance contract, shall contain any waiver or

disclaimer of any of the rights recognized or protected by this regulation.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-060, filed 11/18/91, effective 12/19/91.]

WAC 284-95-070 Transfers to unauthorized insurers. Where a Washington resident owns an insurance contract issued by a company authorized to do business in Washington, that company may not transfer such insurance contract to a company which is not authorized to do business in Washington. Acting as the assuming company in a transfer of insurance involving a Washington risk constitutes the transaction of insurance for which a Washington certificate of authority, license, or registration is required.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-070, filed 11/18/91, effective 12/19/91.]

WAC 284-95-080 Unfair or deceptive acts or practices. It is an unfair or deceptive act or practice, pursuant to RCW 48.30.010, for any transferring company to:

- (1) Be a party to a transfer of insurance contracts which is in violation of the provisions of this regulation; or
- (2) Represent to policyowners, either verbally or in writing, that the commissioner has approved a transfer of insurance contracts. It shall be a false representation in advertising, in the sense of RCW 48.44.110, for a health care service contractor to represent to policyowners, either verbally or in writing, that the commissioner has approved any transfer of insurance contracts. It shall be a false or misleading practice in advertising, in the sense of RCW 48.46.400, and a deceptive, misleading, or unfair practice in advertising, in the sense of RCW 48.46.130 (1)(e), for a health maintenance organization to represent to policyowners, either verbally or in writing, that the commissioner has approved any transfer of insurance contracts; or
- (3) Unfairly discriminate against policyowners who do not consent to the proposed transfer of insurance contracts.

[Statutory Authority: RCW 48.02.060 (3)(a), 48.01.030 and 48.30.010. 91-23-064 (Order R 91-9), § 284-95-080, filed 11/18/91, effective 12/19/91.]

Chapter 284-96 WAC

GROUP AND BLANKET DISABILITY INSURANCE

WAC

284-96-010	Purpose.
284-96-015	Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required.
284-96-020	Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined.
284-96-500	Alternative care—General rules as to minimum standards.

WAC 284-96-010 Purpose. The purpose of this chapter is to provide a consolidated location within Title 284 of the Washington Administrative Code for regulations applying to disability insurance companies marketing group and blanket disability insurance as it is defined in chapter 48.21 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. 92-21-100 (Order R 92-16), § 284-96-010, filed 10/21/92, effective 11/21/92.]

WAC 284-96-015 Experimental and investigational prescriptions, treatments, procedures, or services—Definition required—Standard for definition—Written notice of denial required—Appeal process required. (1) Every group disability insurance policy which excludes or limits, or reserves the right to exclude or limit, benefits for any treatment, procedure, facility, equipment, drug, drug usage, medical device, or supply (hereinafter individually and collectively referred to as services) for one or more medical condition or illness because such services are deemed to be experimental or investigational must include within the policy and any certificate of coverage issued thereunder, a definition of experimental or investigational.

(2) The definition of experimental or investigational services must include an identification of the authority or authorities which will make a determination of which services will be considered to be experimental or investigational. If the group disability insurer specifies that it, or an affiliated entity, is the authority making the determination, the criteria it will utilize to determine whether a service is experimental or investigational must be set forth in the policy and any certificate of coverage issued thereunder. As an example, and not by way of limitation, the requirement to set forth criteria in the policy and any certificate of coverage issued thereunder may be satisfied by using one or more of the following statements, or other similar statements:

(a) "In determining whether services are experimental or investigational, we will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious."

(b) "In determining whether services are experimental or investigational, we will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient."

The supporting documentation upon which the criteria are established must be made available for inspection upon written request in all instances and may not be withheld as proprietary.

(3) Every group disability insurer that denies a request for benefits or that refuses to approve a request to preauthorize services, whether made in writing or through other claim presentation or preauthorization procedures set out in the policy and any certificate of coverage thereunder, because of an experimental or investigational exclusion or limitation, must do so in writing within twenty working days of receipt of a fully documented request. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual. The denial letter must identify by name and job title the individual making the decision and fully disclose:

(a) The basis for the denial of benefits or refusal to preauthorize services;

(b) The procedure through which the decision to deny benefits or to refuse to preauthorize services may be appealed;

(c) What information the appellant is required to submit with the appeal; and

(d) The specific time period within which the company will reconsider its decision.

(4)(a) Every group disability insurer must establish a reasonable procedure under which denials of benefits or refusals to preauthorize services because of an experimental or investigational exclusion or limitation may be appealed. The appeals procedure may be considered reasonable if it provides that:

(i) A final determination must be made and provided to the appellant in writing within twenty working days of receipt of the fully documented appeal. The group disability insurer may extend the review period beyond twenty days only with the informed written consent of the covered individual;

(ii) The appeal must be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

(iii) The appeal must be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse to preauthorize services.

(b) When the initial decision to deny benefits or to refuse to preauthorize services is upheld upon appeal, the written notice shall set forth:

(i) The basis for the denial of benefits or refusal to preauthorize services; and

(ii) The name and professional qualifications of the person or persons reviewing the appeal.

(c) Disclosure of the existence of an appeal procedure shall be made by the group disability insurer in each policy and any certificate of coverage issued thereunder which contains an experimental or investigational exclusion or limitation.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.18.120. 92-21-100 (Order R 92-16), § 284-96-015, filed 10/21/92, effective 11/21/92.]

WAC 284-96-020 Temporomandibular joint disorders—Specified offer of coverage required—Terms of specified offer defined—Proof of offer must be maintained—Discrimination prohibited—Terms defined. (1) Pursuant to RCW 48.21.320, each offer of new or renewal group disability coverage made on or after January 1, 1993, must include one or more offers of optional coverage for the treatment of temporomandibular joint disorders. Group disability insurers are encouraged to exercise broad flexibility in designing benefits for these optional temporomandibular joint disorder coverage offerings. However, compliance with the statute shall be demonstrated only when one of the optional temporomandibular joint disorder coverage offerings provides benefits as follows:

(a) Offers limited to only medical coverage shall provide coverage for medical services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance and copayments. Other than the benefit amount, coverage for medical services shall be the same as are

generally provided in the policy for other injuries or musculoskeletal disorders. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(b) Offers limited to only dental coverage shall provide coverage for dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year, and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for dental services shall be the same as are generally provided in the policy for other injuries or dental conditions. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care dentist; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours, or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(c) Offers of both medical and dental coverage shall provide coverage for medical and dental services related to the treatment of temporomandibular joint disorders in the amount of one thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments, in any calendar year and a lifetime benefit of five thousand dollars per covered individual, after the application of deductibles, coinsurance, and copayments. Other than the benefit amount, coverage for medical and dental services shall be the same as are generally provided in the policy for other injuries, musculoskeletal disorders, or dental conditions. The coverage provisions may require:

(i) That services either be rendered or referred by the covered individual's primary care physician or dentist; and

(ii) A second opinion, provided that the covered individual shall not be financially responsible for any costs relating to this second opinion and that such costs shall be in excess of the required benefit levels; and

(iii) Prenotification or preauthorization.

EXCEPT that the coverage provisions shall not require either a second opinion or prenotification or preauthorization for treatment commencing within forty-eight hours or as soon as is reasonably possible, after the occurrence of an accident or trauma to the temporomandibular joint.

(2) Offers of the optional coverage required by subsection (1) of this section shall be included on the group insurer's application form(s) and retained by the insurer for five years or until the completion of the next examination of the insurer by the insurance commissioner, whichever occurs first. In those cases where there is no written application form, the group insurer shall retain other written evidence of the offer of this optional coverage for temporomandibular joint disorders for the same period of time as required for application forms. This subsection applies only in those cases where the offeree has accepted any coverage.

(3) With respect to both medical and dental optional coverage of disorders of the temporomandibular joint, group disability insurers shall not engage in discriminatory practices against persons submitting claims for that coverage, nor shall they engage in discriminatory practices against licensed health care providers providing services within the scope of their licensure, for the treatment of disorders of the temporomandibular joint. This shall not prejudice the ability of the insurer to limit its coverage to its participating providers.

(4) For the purposes of the optional coverage for disorders of the temporomandibular joint required by subsections (1) through (3) of this section, the following definitions shall apply and shall be contained in the coverage contract:

(a) "Temporomandibular joint disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

(b) "Medical services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good medical practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(c) "Dental services" are those which are:

(i) Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and

(ii) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and

(iii) Recognized as effective, according to the professional standards of good dental practice; and

(iv) Not experimental or primarily for cosmetic purposes.

(5) The requirements listed in the preceding subparagraphs of this section do not apply to those group disability policies exempted by RCW 48.21.320(3) or 48.21.045, or other applicable law.

[Statutory Authority: RCW 48.21.320(2) and 48.02.060 (3)(a). 92-24-045 (Order R 92-23), § 284-96-020, filed 11/25/92, effective 12/26/92.]

[Title 284 WAC—page 320]

WAC 284-96-500 Alternative care—General rules as to minimum standards. (1) As an alternative to hospitalization or institutionalization of an insured and with the intent to cover placement of the insured patient in the most appropriate and cost-effective setting, every group or blanket disability insurance policy, contract or certificate issued, amended, or renewed on or after January 1, 1995, which provides coverage for hospitalization or other institutional expenses to a resident of this state shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

(2) In addition, such expenses may include coverage for durable medical equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

(3) Substitution of less expensive or less intensive services shall be made only with the consent of the insured and upon the recommendation of the insured's attending physician or licensed health care provider that such services will adequately meet the insured patient's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual insured patient.

(4) An insurer may require that home health agencies or similar alternative care providers have written treatment plans which are approved by the insured patient's attending physician or other licensed health care provider.

(5) Coverage may be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the policy or contract, and may include all deductibles and coinsurances which would be payable by the insured under the hospital or other institutional expense coverage of the insured's policy or contract.

(6) This section shall not apply to long-term care, Medicare supplement, or disability income protection insurance policies or contracts. This section shall not apply to guaranteed renewable disability insurance policies issued prior to January 1, 1995.

[Statutory Authority: RCW 48.01.030, 48.02.060, 48.44.050, 48.44.020, 48.46.200 and 48.46.060. 94-19-015 (Order R 94-16), § 284-96-500, filed 9/9/94, effective 10/10/94.]