

Title 284 WAC

INSURANCE COMMISSIONER, OFFICE OF

<p>Chapters</p> <p>284-01</p> <p>284-02</p> <p>284-03</p> <p>284-04</p> <p>284-05</p> <p>284-07</p> <p>284-12</p> <p>284-13</p> <p>284-15</p> <p>284-16</p> <p>284-17</p> <p>284-17A</p> <p>284-17B</p> <p>284-18</p> <p>284-18A</p> <p>284-19</p> <p>284-20</p> <p>284-20A</p> <p>284-20B</p> <p>284-20C</p> <p>284-21</p> <p>284-22</p> <p>284-23</p> <p>284-24</p> <p>284-24A</p> <p>284-24B</p> <p>284-24C</p> <p>284-24D</p> <p>284-24E</p> <p>284-26</p> <p>284-28</p> <p>284-30</p> <p>284-34</p>	<p>Electronic authentication.</p> <p>Description of insurance commissioner's office—Organization operations and obtaining information.</p> <p>Public records.</p> <p>Privacy of consumer financial and health information.</p> <p>Washington actuaries regulation.</p> <p>Requirements as to company reports and annual statements.</p> <p>Agents, brokers and adjusters.</p> <p>Assets—Liabilities—Investments and reinsurance.</p> <p>Surplus line insurance.</p> <p>Insurers.</p> <p>Licensing requirements and procedures.</p> <p>Communications equipment licenses.</p> <p>Rental car agent.</p> <p>Washington insurance holding company regulation.</p> <p>Health care service contractor and health maintenance holding company regulation.</p> <p>Washington essential property insurance inspection and placement program.</p> <p>Insurance policies.</p> <p>Rules that apply to insurers that underwrite medical malpractice insurance.</p> <p>Rules for filing property and casualty forms.</p> <p>Rules for filing motor vehicle service contracts.</p> <p>Standard forms.</p> <p>USL&H assigned risk plan.</p> <p>Washington life insurance regulations.</p> <p>Rates.</p> <p>Rules that apply to insurers that use credit history for personal insurance underwriting or rating.</p> <p>Rules that require property and casualty insurers to report statistical data.</p> <p>Specific rules that apply to statistical plans for medical professional liability reports.</p> <p>Medical malpractice closed claim data reporting rules for facilities and providers.</p> <p>Medical malpractice claim settlement data reporting rules for attorneys and claimants.</p> <p>Insider trading of equity securities of a domestic stock insurance company.</p> <p>Proxies, consents, and authorizations of domestic stock insurers.</p> <p>Trade practices.</p> <p>Credit life and credit accident and health insurance.</p>	<p>284-36</p> <p>284-36A</p> <p>284-37</p> <p>284-43</p> <p>284-44</p> <p>284-46</p> <p>284-48</p> <p>284-49</p> <p>284-50</p> <p>284-51</p> <p>284-52</p> <p>284-53</p> <p>284-54</p> <p>284-55</p> <p>284-58</p> <p>284-60</p> <p>284-66</p> <p>284-74</p> <p>284-78</p> <p>284-83</p> <p>284-84</p> <p>284-85</p> <p>284-87</p> <p>284-90</p> <p>284-91</p> <p>284-92</p> <p>284-95</p> <p>284-96</p> <p>284-97</p>	<p>Domestic fraternal mutual property insurers' agents and directors.</p> <p>Fraternal benefit societies.</p> <p>Market conduct oversight program.</p> <p>Health carriers and health plans.</p> <p>Health care services contractors—Agents—Contract formats—Standards.</p> <p>Health maintenance organizations.</p> <p>Bulletins.</p> <p>Washington basic coverage policy (small group) insurance regulation.</p> <p>Washington disability insurance regulations.</p> <p>Standards for coordination of benefits.</p> <p>Conversion regulation.</p> <p>Standards for coverage of chemical dependency.</p> <p>Long-term care insurance rules.</p> <p>Medicare supplement insurance regulation.</p> <p>Life and disability form and rate filings.</p> <p>Disability insurance loss ratios.</p> <p>Washington medicare supplement insurance regulation.</p> <p>Approved insurance tables.</p> <p>Joint underwriting association for day care insurance.</p> <p>Long-term care insurance rules.</p> <p>Fixed premium universal life insurance.</p> <p>Long-term care partnership.</p> <p>Joint underwriting association for midwifery and birthing centers malpractice insurance.</p> <p>Rules pertaining to AIDS.</p> <p>Washington state health insurance pool.</p> <p>Liability risk retention.</p> <p>Transfer of insurance contracts.</p> <p>Group and blanket disability insurance.</p> <p>Viatical settlement regulation.</p>
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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 284-10

SHORT-TERM HEALTH INSURANCE REFORM

- 284-10-010 Purpose, intent, and authority. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-015 Scope and applicability. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-020 Definitions. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-030 Portability of health insurance benefits. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-050 Restrictions on the denial, exclusion, or limitation of health benefits for preexisting conditions. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-060 Guaranteed renewability—Health insurance. Purpose, intent, and authority. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-070 Certification of withdrawal from the market and exemption from short-term reform rules. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-10-090 Severability provision. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050,

48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

284-10-140

Recognizing the exercise of conscience by purchasers of basic health plan services and ensuring access for all enrollees to such services. [Statutory Authority: RCW 48.43.065 and 48.02.060. 96-04-060 (Order R 95-9), § 284-10-140, filed 2/6/96, effective 3/8/96.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

Chapter 284-14

REGULATIONS PERTAINING TO FEES AND TAXES

- 284-14-010 Filing fee for rates and forms. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-010, filed 10/6/82.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-14-020 Filing transmittal information. [Statutory Authority: RCW 48.02.060. 82-20-090 (Order R 82-4), § 284-14-020, filed 10/6/82.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

Chapter 284-32

PLAN OF OPERATION FOR WASHINGTON INSURANCE GUARANTY ASSOCIATION

- 284-32-010 Purpose. [Emergency and Permanent Order R-71-3, § 284-32-010, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-020 Board of directors. [Emergency and Permanent Order R-71-3, § 284-32-020, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-030 Officers of board. [Emergency and Permanent Order R-71-3, § 284-32-030, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-040 Quorum, votes required, proxies. [Emergency and Permanent Order R-71-3, § 284-32-040, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-050 Annual meetings. [Emergency and Permanent Order R-71-3, § 284-32-050, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-060 Board's annual meeting. [Emergency and Permanent Order R-71-3, § 284-32-060, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-070 Meeting after notice of insolvency. [Emergency and Permanent Order R-71-3, § 284-32-070, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-080 Other meetings. [Emergency and Permanent Order R-71-3, § 284-32-080, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-090 Expenses of board members. [Emergency and Permanent Order R-71-3, § 284-32-090, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-100 Official address of association. [Emergency and Permanent Order R-71-3, § 284-32-100, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-110 Bank accounts, borrowing power. [Emergency and Permanent Order R-71-3, § 284-32-110, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-120 Board may levy fee. [Emergency and Permanent Order R-71-3, § 284-32-120, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-130 Contract with servicing facility. [Emergency and Permanent Order R-71-3, § 284-32-130, filed 12/9/71.]

- Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-32-140 Claim settlements of one hundred fifty thousand dollars or more. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-150 Prevention of insolvencies. [Emergency and Permanent Order R-71-3, § 284-32-150, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-160 Records, reports, audit. [Emergency and Permanent Order R-71-3, § 284-32-160, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-170 Appeal. [Emergency and Permanent Order R-71-3, § 284-32-170, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-180 Indemnification. [Emergency and Permanent Order R-71-3, § 284-32-180, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-190 Conformity to statute. [Emergency and Permanent Order R-71-3, § 284-32-190, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-32-200 Effective date. [Emergency and Permanent Order R-71-3, § 284-32-200, filed 12/9/71.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

**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 284-01 WAC
ELECTRONIC AUTHENTICATION**

WAC

- 284-01-050 Provisions relating to electronic authentication.

WAC 284-01-050 Provisions relating to electronic authentication. (1) The term "deliver" as used in Title 48 RCW and Title 284 WAC includes delivery by message, as

"message" is defined in RCW 19.34.020. Where any provision in Title 48 RCW or Title 284 WAC requires that a writing be given or mailed to someone or left with someone or the like, the requirement is satisfied by delivery of a message, as "message" is defined in RCW 19.34.020.

(2) Where any provision in Title 48 RCW or Title 284 WAC requires that something be "written," or otherwise requires a writing, that requirement is met by anything that is a "writing" within the meaning of RCW 19.34.320.

(3) Where any provision in Title 48 RCW or Title 284 WAC requires that something be "signed," or otherwise requires a signature, that requirement is met by anything that is deemed "signed" under RCW 19.34.300.

[Statutory Authority: RCW 48.02.060. 98-04-063 (Matter No. R 97-6), § 284-01-050, filed 2/2/98, effective 3/5/98.]

Chapter 284-02 WAC

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

WAC

- 284-02-010 What are the responsibilities of the insurance commissioner and the office of the insurance commissioner (OIC) staff?
- 284-02-023 How is the OIC organized?
- 284-02-025 How is the OIC funded?
- 284-02-030 How can service of process over foreign and alien insurers be made?
- 284-02-040 Where can information about applying for a license as agent, adjuster, broker, or solicitor be found?
- 284-02-050 Where can information and applications for admission as an authorized insurer, fraternal benefit society, health care service contractor, health maintenance organization, viatical settlement provider, and for other entities required to be authorized to transact the business of insurance be found?
- 284-02-060 Where can information regarding filing a complaint against a company, agent, broker, solicitor, adjuster, or other person or entity authorized by the OIC be found?
- 284-02-070 How does the OIC conduct hearings?
- 284-02-080 What publications and information are available from the OIC?
- 284-02-100 How can an interested person petition for adoption, amendment, or repeal of rules?
- 284-02-105 What does "sending" or "delivery" include?

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 284-02-020 Organization and operations. [Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-020, filed 4/10/96, effective 5/11/96. 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.] Repealed by 07-01-048 (Matter No. R 2003-09), filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220.
- 284-02-090 Public access to information and records. [Order R-75-2, § 284-02-090, filed 5/19/75.] Repealed by 07-01-048 (Matter No. R 2003-09), filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220.

WAC 284-02-010 What are the responsibilities of the insurance commissioner and the office of the insurance commissioner (OIC) staff? The insurance commissioner is responsible for regulating the insurance industry and all persons or entities transacting insurance business in this state in the public interest. The position of insurance commissioner was established by the legislature as an independent, elective office in 1907. The insurance laws and the authority of the insurance commissioner are found in Title 48 RCW. The insurance commissioner's powers are set forth in chapter 48.02 RCW.

(1) General powers and tasks.

(a) To carry out the task of enforcing the insurance code the commissioner:

(i) May make rules and regulations governing activities under the insurance code (Title 48 RCW);

(ii) May conduct investigations to determine whether any person has violated any provision of the insurance code, including both informal and formal hearings;

(iii) May take action (including levying of fines and revocation of authority to transact business in this state) against an insurance company, fraternal benefit society, charitable gift annuity providers, health maintenance organization, health care service contractor, motor vehicle service contract provider, service contract provider, protection product guarantee providers, self-funded multiple employer welfare arrangement, and viatical settlement provider; and

(iv) May issue, revoke, or suspend the licenses of insurance agents, brokers, solicitors, adjusters, and insurance education providers, reinsurance intermediaries, viatical settlement brokers, or may fine any of them for violations of the insurance code.

(b) All insurers and other companies regulated under the insurance code must meet financial, legal, and other requirements and must be licensed, registered, or certified by the OIC prior to the transaction of insurance in this state.

(c) The OIC is responsible for collecting a premium-based tax levied against insurers and other companies transacting insurance business in this state. The funds collected from health care companies are deposited into the state's health services account. All other taxes are deposited into the state's general fund.

(d) Any person engaged in the marketing or sale of insurance in Washington must hold a license issued by the OIC. The OIC oversees the preclicensing education, testing, licensing, continuing education, and renewal of agent, broker, and solicitor licenses.

(e) Public and independent adjusters must be licensed by the OIC. The OIC is responsible for the processing of licenses, background checks, affiliations, testing, renewals, terminations, and certificates for individuals and business entities, both resident and nonresident, who act as independent or public adjusters in Washington.

(f) The OIC assists persons who have complaints about companies, agents, or other licensees of the OIC. OIC investigators follow up on consumer complaints, look into circumstances of disputes between consumers and licensees, and respond to questions.

(g) The OIC publishes and distributes consumer guides and fact sheets to help inform consumers about their choices and rights when buying and using insurance.

(2) **Orders.** The commissioner may issue a cease and desist order based on the general enforcement powers granted by RCW 48.02.080, or may bring an action in court to enjoin violations of the insurance code.

(3) **SHIBA.** The OIC offers assistance statewide to consumers regarding health care insurance and health care access through its statewide health insurance benefits advisors (SHIBA) "HelpLine" program. Volunteers are trained by OIC employees to provide counseling, education, and other assistance to residents of Washington. Information about SHIBA, including how to become a SHIBA volunteer, can be found on the OIC web site (www.insurance.wa.gov).

(4) **Publication of tables for courts and appraisers.** The insurance commissioner publishes tables showing the average expectancy of life and values of annuities and life and term estates for the use of the state courts and appraisers (RCW 48.02.160).

(5) **Copies of public documents.** Files of completed investigations, complaints against insurers or other persons or entities authorized to transact the business of insurance by the OIC, and copies of completed rate or form filings are generally available for public inspection and copying during business hours (see chapter 284-03 WAC) at the OIC's office in Tumwater, subject to other applicable law. Access by the public to information and records of the insurance commissioner is governed by chapter 284-03 WAC and the Public Records Act (chapter 42.56 RCW). Information on how to request copies of public documents is available on the OIC web site (www.insurance.wa.gov).

(6) **Web site.** The insurance commissioner maintains a web site at: www.insurance.wa.gov. Current detailed information regarding insurance, persons and entities authorized to transact insurance business in this state, consumer tips, links to Washington's insurance laws and rules, a list of publications available to the public, and other valuable information can be found on the web site.

(7) **Toll-free consumer hotline.** Members of the OIC staff respond to inquiries of consumers who telephone the agency's toll-free consumer hotline at 1-800-562-6900.

(8) **Location of offices.** The OIC's headquarters office is located in the insurance building on the state Capitol campus in Olympia. Branch offices are located in Tumwater, Seattle and Spokane. Addresses for the office locations can be found on the OIC web site (www.insurance.wa.gov) or by calling the commissioner's consumer hotline (1-800-562-6900).

(9) **Antifraud program.** Beginning in 2007, the OIC (in partnership with the Washington state patrol, county prosecutors, and the state attorney general's office) will investigate and assist in prosecuting fraudulent activities against insurance companies. Information about this program can be found on the OIC web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-010, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-010, filed 4/10/96, effective 5/11/96. 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 284-02-023 How is the OIC organized? The insurance commissioner is elected by popular vote every four years. The commissioner is assisted by a chief deputy insur-

ance commissioner. The agency is divided into three line divisions, with four smaller divisions providing direct support. The line divisions are: Company supervision, consumer protection, and rates and forms. The support divisions are: Operations, legal affairs, public affairs, legislation, and policy. An up-to-date agency organizational chart can be requested from the OIC.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-023, filed 12/14/06, effective 1/14/07.]

WAC 284-02-025 How is the OIC funded? The operations of the OIC are funded by a special assessment paid by all insurance companies based on the amount of insurance business they transact in Washington.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-025, filed 12/14/06, effective 1/14/07.]

WAC 284-02-030 How can service of process over foreign and alien insurers be made? (1) Although domestic insurers are served with legal process personally, the insurance commissioner is the party on whom service of process must 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.

(a) Service of process against authorized foreign and alien insurers, other than surplus line insurers, must be made according to the requirements of RCW 48.05.200 and 48.05.-210. RCW 48.05.220 specifies the proper venue for such actions.

(b) Service of process against surplus line insurers can be made on the commissioner by following 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.)

(c) Service of process against other unauthorized insurers may be made on the commissioner based on the procedures set forth in RCW 48.05.215.

(d) The commissioner is not authorized to accept service of process on domestic or foreign health care service contractors or health maintenance organizations.

(2) Where service of process against a foreign or alien insurer is made through service upon the commissioner (according to the requirements of RCW 48.05.210 or 48.05.-215), against a nonresident agent or broker (RCW 48.17.-340), or against a viatical settlement provider or broker (chapter 48.102 RCW or chapter 284-97 WAC), this service must be made by personal service at, or by registered mail sent to, the Tumwater office of the insurance commissioner only, and must otherwise comply with the requirements of the applicable statute.

(3) Service upon any location other than the Tumwater office of the OIC is not permissible and will not be accepted.

(4) As authorized by 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 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-030, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-030, filed 4/10/96, effective 5/11/96. 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.]

(2009 Ed.)

WAC 284-02-040 Where can information about applying for a license as agent, adjuster, broker, or solicitor be found? The requirements for licensing are generally found in chapter 48.17 RCW.

(1) Licensing requirements and instructions for obtaining a license as an insurance agent, adjuster, broker or solicitor, as a viatical settlement broker, or for any other license required for the transaction of the business of insurance under Title 48 RCW may be obtained from the OIC's licensing section.

(2) The OIC web site includes forms and instructions for applicants at: www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-040, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-040, filed 4/10/96, effective 5/11/96. 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 Where can information and applications for admission as an authorized insurer, fraternal benefit society, health care service contractor, health maintenance organization, viatical settlement provider, and for other entities required to be authorized to transact the business of insurance be found? (1) A checklist of documents required for an application for admission is available from the company supervision division. 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 48.102 RCW (viatical settlement providers); chapter 48.44 RCW (health care service contractors), chapter 48.46 RCW (health maintenance organizations) and chapter 48.125 RCW (self-funded multiple employer welfare arrangements).

(2) Capital and surplus requirements for stock insurance companies are contained in RCW 48.05.340.

(3) The OIC web site includes forms and instructions for applicants at: www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-050, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-050, filed 4/10/96, effective 5/11/96. 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 Where can information regarding filing a complaint against a company, agent, broker, solicitor, adjuster, or other person or entity authorized by the OIC be found? (1) A complaint or grievance against a person or entity authorized to transact the business of insurance under Title 48 RCW may be filed with the OIC. The complainant should supply as many facts as possible to assist the OIC in the investigation of the complaint. Complaints should include: The correct name of the insurance company or other entity issuing the policy or contract; the policy number; the claim number; the name of the agent, broker, solicitor, adjuster, viatical settlement broker, or any other person or entity offering to sell you insurance or to settle your claim; the date of loss or the date of the company's or other lic-

ensee's action; and a complete explanation of the loss or other problem.

(2) A form that can be used to make a complaint may be requested from the OIC by telephone or can be found on the OIC web site (www.insurance.wa.gov). Use of this form may be helpful in organizing the information, but its use is not required.

(3) If personal medical information is provided to the OIC, the OIC's medical release form must be signed and submitted by the appropriate person.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-060, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-060, filed 4/10/96, effective 5/11/96. 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 How does the OIC conduct hearings? (1) Generally.

(a) Hearings of the OIC are conducted according to chapter 48.04 RCW and the Administrative Procedure Act (chapter 34.05 RCW). In addition to general hearings conducted pursuant to RCW 48.04.010, two specific types of hearings are conducted pursuant to the Administrative Procedure Act: Rule-making hearings and adjudicative proceedings or contested case hearings. Contested case hearings include appeals from disciplinary actions taken by the commissioner.

(b) **How to demand or request a hearing.** 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 the failure is deemed an act under the insurance code or the Administrative Procedure Act.

(i) Hearings can be demanded by an aggrieved person based on any report, promulgation, or order of the commissioner.

(ii) Requests for hearings must be in writing and delivered to the Tumwater office of the OIC. The request must specify how the person making the demand has been aggrieved by the commissioner, and must specify the grounds to be relied upon as the basis for the relief sought.

(c) Accommodation will be made for persons needing assistance, for example, where English is not their primary language, or for hearing impaired persons.

(2) Proceedings for contested cases or adjudicative hearings.

(a) Provisions specifically relating to disciplinary action taken against persons or entities authorized by the OIC to transact the business of insurance are contained in RCW 48.17.530, 48.17.540, 48.17.550, 48.17.560, chapter 48.102 RCW, and other chapters related to specific licenses. 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 appear in Title 10 of the Washington Administrative Code. 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 actions against viatical settlement providers are found in chapter 48.102 RCW; grounds for actions 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. Grounds for actions against other persons or entities authorized by the OIC under Title 48 RCW are found in the chapters of Title 48 RCW applicable to those licenses.

(b) The insurance commissioner may suspend or revoke any license, certificate of authority, or registration issued by the OIC. In addition, the commissioner may generally levy fines against any persons or organizations having been authorized by the OIC.

(c) Adjudicative proceedings or contested case hearings of the insurance commissioner are informal in nature, and compliance with the formal rules of pleading and evidence is not required.

(i) The insurance commissioner may delegate the authority to hear and determine the matter and enter the final order under RCW 48.02.100 and 34.05.461 to a presiding officer; or may use the services of an administrative law judge in accordance with chapter 34.12 RCW and the Administrative Procedure Act (chapter 34.05 RCW). The initial order of an administrative law judge will not become a final order without the commissioner's review (RCW 34.05.464).

(ii) The hearing will be recorded by any method chosen by the presiding officer. Except as required by law, the OIC is not required, at its expense, to prepare a transcript. Any party, at the party's expense, may cause a reporter approved by the presiding officer 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 insurance commissioner's order is made to the superior court, the recording of the hearing will be transcribed and certified to the court.

(iii) The insurance commissioner or the presiding officer may allow any person affected by the hearing to be present during the giving of all testimony and will allow the aggrieved person a reasonable opportunity to inspect all documentary evidence, to examine witnesses, and to present evidence. Any person heard must make full disclosure of the facts pertinent to the inquiry.

(iv) Unless a person aggrieved by an order of the insurance commissioner demands a hearing within ninety days after receiving notice of that order, or in the case of persons or entities authorized by the OIC to transact the business of insurance under Title 48 RCW, within ninety days after the order was mailed to the most recent address shown in the OIC's licensing records, the right to a hearing is conclusively deemed to have been waived (RCW 48.04.010(3)).

(v) Prehearing or other conferences for settlement or simplification of issues may be held at the discretion and direction of the presiding officer.

(3) **Rule-making hearings.** Rule-making hearings are conducted based on requirements found in the Administrative Procedure Act (chapter 34.05 RCW) and chapter 34.08 RCW (the State Register Act).

(a) Under applicable law all interested parties must be provided an opportunity to express their views concerning a

proposed rule, either orally or in writing. The OIC will accept comments on proposed rules by mail, electronic telefacsimile transmission, or electronic mail but will not accept comments by recorded telephonic communication or voice mail (RCW 34.05.325(3)).

(b) Notice of intention of the insurance commissioner to adopt a proposed rule or amend an existing rule is published in the state register and is sent to anyone who has requested notice in advance and to persons who the OIC determines would be particularly interested in the proceeding. Persons requesting paper copies of all proposed rule-making notices of inquiry and hearing notices may be required to pay the cost of mailing these notices (RCW 34.05.320(3)).

(c) Copies of proposed new rules and amendments to existing rules as well as information related to how the public may file comments are available on the OIC web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 34.05.220, 08-14-170 (Matter No. R 2008-10), § 284-02-070, filed 7/2/08, effective 8/2/08; 07-01-048 (Matter No. R 2003-09), § 284-02-070, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b), 96-09-038 (Matter No. R 96-3), § 284-02-070, filed 4/10/96, effective 5/11/96. 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 What publications and information are available from the OIC? The OIC makes information about insurance, persons and entities authorized by the OIC to transact the business of insurance under Title 48 RCW, policy forms and rates, interpretive statements, and official actions taken by the insurance commissioner available to the public. Below is a description of some of the information published by the OIC. Copies of these reports and publications, as well as consumer fact sheets and purchasing guides, are available on the OIC web site (www.insurance.wa.gov), at all OIC offices, and may be ordered by telephone (1-800-562-6900). Persons requesting paper copies may be required to pay the cost of producing and mailing the publication.

(1) **Insurance code.** The insurance commissioner publishes a paperbound copy of the insurance laws (Title 48 RCW) as required by RCW 48.02.180, and the insurance administrative rules (Title 284 WAC). Copies of these pamphlets may be purchased from the commissioner's Tumwater 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.** Except as provided in chapter 48.15 RCW, an insurer not authorized to do business in Washington is forbidden by law to solicit business in Washington (RCW 48.15.020). The OIC compiles a list of all insurance companies authorized to do business in this state. A paper copy of the list is available from the OIC, and it is available on the OIC web site (www.insurance.wa.gov). The commissioner may require persons requesting paper copies of the list of authorized and registered companies to pay the cost of producing and mailing this list.

(3) **Annual report.** The insurance commissioner publishes an annual report, as required by RCW 48.02.170. 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. The report is available on the OIC web site (www.insurance.wa.gov). A paper copy of the report is available upon request. The commissioner may require persons requesting a paper copy to pay the cost of developing, printing, and mailing the annual report.

(4) **Policy and contract forms and rates.** Rates of insurance companies and other entities offering contracts in this state, and all policy forms required to be filed or approved by the insurance commissioner are on file in the commissioner's Tumwater office and are public records. For all lines of insurance except property and casualty insurance, actuarial formulas, statistics, and assumptions submitted in support of a rate or form filing are not available for public inspection (RCW 48.02.120(3)). (For property and casualty insurance, see RCW 48.19.040(5).)

(5) **Examination reports, annual reports.** Reports of examination and annual reports of insurance companies, fraternal benefit societies, viatical settlement providers, health care service contractors, health maintenance organizations, and other entities authorized to transact the business of insurance under Title 48 RCW are on file in the insurance commissioner's Tumwater office and are open for public inspection. Instructions for viewing or copying public records are available on the OIC web site (www.insurance.wa.gov).

(6) **Official actions of the insurance commissioner.** As required by the Administrative Procedure Act, actions taken by the OIC relating to adoption of rules or the discipline of persons or entities authorized by the OIC are on file in the commissioner's Tumwater 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 Tumwater office.

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

[Statutory Authority: RCW 48.02.060 and 34.05.220, 07-01-048 (Matter No. R 2003-09), § 284-02-080, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b), 96-09-038 (Matter No. R 96-3), § 284-02-080, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 48.02.060 (3)(a), 88-23-079 (Order R 88-10), § 284-02-080, filed 11/18/88; Order R-68-6, § 284-02-080, filed 8/23/68, effective 9/23/68.]

WAC 284-02-100 How can an interested person petition for adoption, amendment, or repeal of rules? (1) As authorized by the Administrative Procedure Act, any interested person may petition the insurance commissioner requesting the adoption, amendment, or repeal of any rule (RCW 34.05.330). The petition must be in writing, dated, and signed by the petitioner. In addition to the information listed in RCW 34.05.330(3), each petition must include the following information:

(a) The name and address of the person requesting the action, and, if relevant, 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 the statutory authority relied upon by the petitioner, how the rule is to be implemented, the reasons for the proposed action, accompanied by necessary or pertinent data in support of the new rule or amendment; and

(d) Statements from other persons in support of the action petitioned are encouraged, if they help the OIC to understand why the new rule or amendment is needed.

(2)(a) Within sixty days after the petition to adopt, amend, or repeal any rule is submitted, the OIC either:

(i) Will formally deny the petition in writing to the person requesting the action, stating the reasons for the denial, and, if appropriate, will state any alternative means by which the insurance commissioner will address concerns raised; or

(ii) Will initiate rule-making proceedings in accordance with the Administrative Procedure Act.

(b) If the insurance commissioner denies a petition to repeal or amend a rule, the petitioner may appeal the denial to the governor, within thirty days after the denial (RCW 34.05.330(2)).

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

(4) For information concerning the subjects of rules being proposed, or to request paper copies of rules or copies of materials presented to the commissioner during the rule-making process, members of the public may contact the agency's rules coordinator. The name, address, and phone number of the rules coordinator are available on the OIC web site and are published at least annually in the *Washington State Register*. Complete information regarding all rules being proposed is available on the OIC web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060 and 34.05.220. 07-01-048 (Matter No. R 2003-09), § 284-02-100, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 48.02.060 and 34.05.220 (1)(b). 96-09-038 (Matter No. R 96-3), § 284-02-100, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 48.02.060 (3)(a). 88-23-079 (Order R 88-10), § 284-02-100, filed 11/18/88.]

WAC 284-02-105 What does "sending" or "delivery" include? Throughout Title 284 WAC, whenever written notice is required to be sent or delivered to the commissioner, "sending" or "delivery" includes transmitting the required information in writing and, where appropriate, on forms designated by the commissioner for that purpose via first class mail, commercial parcel delivery company, electronic telefacsimile, or e-mail, unless the relevant requirement specifies sending the written notice in some specific manner, such as via first class mail, postage prepaid.

[Statutory Authority: RCW 48.02.060 and 34.05.220. 08-14-170 (Matter No. R 2008-10), § 284-02-105, filed 7/2/08, effective 8/2/08.]

Chapter 284-03 WAC PUBLIC RECORDS

WAC

PUBLIC RECORDS REQUESTS

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284-03-030	How will the OIC respond to my public record request?
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USE AND PROTECTION OF PERSONAL INFORMATION BY THE OIC

284-03-100	If I make a complaint or inquiry, how will the OIC use that information?
284-03-105	Will the OIC protect my personal information?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-03-080	Requests for public records. [Order R-75-1, § 284-03-080, filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-090	Copying fees. [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.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-110	Review of denials of public records request. [Order R-75-1, § 284-03-110, filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-120	Protection of public records. [Order R-75-1, § 284-03-120, filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-130	Consumer complaints and inquiries. [Order R-75-1, § 284-03-130, filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-140	Adoption of forms. [Order R-75-1, § 284-06-140 (codified as WAC 284-03-140), filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-990	Form 276-1—Request for inspection of records. [Order R-75-1, Form 276-1 (codified as WAC 284-03-990), filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.
284-03-99001	Form 276-2—Request for photocopy of record(s). [Order R-75-1, Form 276-2 (codified as WAC 284-03-99001), filed 5/19/75.] Repealed by 04-15-157 (Matter No. R 2003-10), filed 7/21/04, effective 8/21/04. Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250.

PUBLIC RECORDS REQUESTS

WAC 284-03-005 What is a public record? "Public record" is defined in RCW 42.17.020. Public records include any written or recorded communication containing information relating to the conduct of the OIC or the performance of any governmental or proprietary function prepared, owned, used, or retained by the OIC.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-005, filed 7/21/04, effective 8/21/04.]

WAC 284-03-010 Who should I contact about a public record request? The public records officer is in charge of all records maintained by the office of the insurance commissioner (OIC). This includes records at any office in the state maintained by the insurance commissioner. The public records officer is responsible for overseeing the release of public records, coordinating OIC public disclosure staff, and maintaining the records indexes.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-010, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-010, filed 5/19/75.]

WAC 284-03-015 How do I make a public record request? Public record requests must be made in writing. The OIC accepts written public record requests made in person or sent by e-mail, fax, or mail. Requests will be accepted either:

- (1) On an OIC Public Disclosure Request form. The forms are available on the OIC web site or by contacting the public records officer; or
- (2) If the OIC form is not used, the public record request should be in writing and include the following information:
 - (a) The name of the person requesting the record;
 - (b) The calendar date on which the request was made;
 - (c) A sufficient description of the record requested; and
 - (d) If the information you are requesting may include a list of individuals, a statement that the list will not be used for commercial purposes.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-015, filed 7/21/04, effective 8/21/04.]

WAC 284-03-020 What records indexes are available? The OIC does not maintain or have custody of all agency records. Historical records are sent to the secretary of the state's archives division. The OIC maintains a current index providing identifying information regarding OIC public records. The index is available to all persons under the same rules and on the same conditions as are applied to public records available for inspection. The records are indexed:

- (1) By appropriate names;
- (2) By calendar year;
- (3) By topic; or
- (4) A combination of the above methods, as appropriate.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-020, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-020, filed 5/19/75.]

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WAC 284-03-025 Is the OIC required to create public records for me? The Public Disclosure Act (RCW 42.17.250 through 42.17.348) requires access to existing, identifiable public records in an agency's possession at the time of the request (see RCW 42.17.270). The OIC is not required to collect or organize data to create a public record that does not exist at the time of the public record request.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-025, filed 7/21/04, effective 8/21/04.]

WAC 284-03-030 How will the OIC respond to my public record request? (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.

Within five business days after receiving a request, the OIC will either:

- (a) Provide the record(s);
- (b) Acknowledge your request and give you a reasonable estimate of how long the agency will take to provide records. If your request is not clear, the OIC may ask you for more information (see WAC 284-03-035); or
- (c) Deny all or part of the request in writing, with reasons for the denial (see WAC 284-03-040 and 284-03-045). The explanation will include the law the OIC relied upon in its denial. Every denial will be sent to the public records officer for review as required by RCW 42.17.320.

(2) At his or her discretion, the public records officer may send the requested records to you by e-mail, fax, or mail. The records may be delivered on computer or compact disks, or by use of other methods of transmittal or storage.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-030, filed 7/21/04, effective 8/21/04; Order R-75-1, § 234-03-030 (codified as WAC 284-03-030), filed 5/19/75.]

WAC 284-03-035 Why might the OIC need to extend the time to respond to a public record request? The OIC may need to extend the time to respond to a public record request to:

- (1) Locate and gather the information requested;
- (2) Notify an individual or organization affected by the request;
- (3) Determine whether the information requested is exempt from disclosure and whether all or part of the public record requested can be released; or
- (4) Contact you to clarify the intent, scope or specifics of the request. If you fail to clarify the request, the OIC may not have to respond to your request.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-035, filed 7/21/04, effective 8/21/04.]

WAC 284-03-040 What happens if the public record I requested is exempt from disclosure? If the OIC determines that a record is exempt from disclosure, you will be informed in writing of the specific exemption authorizing the OIC to withhold the record.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-040, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-040, filed 5/19/75.]

WAC 284-03-045 What happens if only part of the record I requested is exempt? The OIC may delete identifying details or other information when there is reason to believe the information is not subject to disclosure (see RCW 42.17.260 for an example). The public records officer will explain any deletion in writing.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-045, filed 7/21/04, effective 8/21/04.]

WAC 284-03-050 Will the OIC review the denial of my request? If the OIC denies your public record request, you may ask the OIC to review the denial. To request a review, you must:

- (1) Make your request in writing;
- (2) Specifically refer to the written exemption provided by the OIC; and
- (3) Address the request for review to the OIC's public records officer.

After receiving your request for review, the public records officer will refer the matter for review to the insurance commissioner or a designated deputy insurance commissioner. The commissioner or designee will either affirm or reverse the denial within two business days after the receipt of your request for review.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-050, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-050, filed 5/19/75.]

WAC 284-03-055 What are the fees to copy or inspect records? There is no cost to inspect records. Copying or duplicating fees are intended to equal the costs to the OIC, including costs of materials, machinery, and personnel. The fees charged will be reviewed periodically to assure their accuracy (see RCW 42.17.300). Contact the public records officer or check the OIC web site to find out the current fees.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-055, filed 7/21/04, effective 8/21/04.]

WAC 284-03-060 What records can I inspect and/or copy? You may inspect or get copies of all public records unless they are exempted by chapter 42.17 RCW, Title 48 RCW, chapter 19.108 or 70.02 RCW, or other applicable law.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-060, filed 7/21/04, effective 8/21/04. 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 284-03-065 When can I inspect or copy documents? You can inspect and copy public records at the OIC headquarters in Thurston County from 8:30 a.m. to noon and 1:00 p.m. to 4:30 p.m., Monday through Friday. Records are not available for inspection or copying on legal holidays. The OIC reserves the right to restrict your ability to examine or copy public records when the OIC believes it is necessary to preserve public records or prevent interference in the performance of agency duties. This does not prevent OIC from providing you with copies of the public records or limit the duty of the OIC to provide you with copies of the public records.

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[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-065, filed 7/21/04, effective 8/21/04.]

WAC 284-03-070 Do I need to make an appointment? Appointments are not required but help the OIC provide prompt and efficient service. Since public records facilities and staff are limited, you should make an appointment with the public records officer. When making an appointment, please tell the public records officer what record(s) you would like to inspect or copy. Some records may be offsite, may need to be identified, or may be exempt from disclosure.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-070, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-070, filed 5/19/75.]

WAC 284-03-075 Can I take original records away from the OIC's office? No. You cannot take original records from the OIC's building. The OIC has a duty to protect public records (see RCW 42.17.290).

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-075, filed 7/21/04, effective 8/21/04.]

USE AND PROTECTION OF PERSONAL INFORMATION BY THE OIC

WAC 284-03-100 If I make a complaint or inquiry, how will the OIC use that information? The OIC will use the information you provide in a consumer complaint or inquiry to attempt to resolve your issue or inquiry. This includes contacting the business or person you complained about and any other persons, governments, businesses, or entities that may help the OIC resolve your complaint. If you do not wish the information to be disclosed by the OIC, you must state that in writing to the OIC. This may prevent the OIC from assisting you in resolving your issue.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-100, filed 7/21/04, effective 8/21/04; Order R-75-1, § 284-03-100, filed 5/19/75.]

WAC 284-03-105 Will the OIC protect my personal information? The OIC reserves the right to protect personal information, including health information, as permitted by RCW 42.17.250 through 42.17.348, chapter 70.02 RCW, Title 48 RCW, and other applicable state or federal laws.

[Statutory Authority: RCW 48.02.060, 48.17.250, 48.17.300, 70.02.050 and 42.17.250. 04-15-157 (Matter No. R 2003-10), § 284-03-105, filed 7/21/04, effective 8/21/04.]

Chapter 284-04 WAC

PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION

WAC

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PART 1
 GENERAL PROVISIONS

WAC 284-04-120 Definitions. As used in this chapter, unless the context requires otherwise:

(1) "Affiliate" means any company that controls, is controlled by or is under common control with another company.

(2) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

Examples.

(a) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(i) Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

(ii) Uses short explanatory sentences or bullet lists whenever possible;

(iii) Uses definite, concrete, everyday words and active voice whenever possible;

(iv) Avoids multiple negatives;

(v) Avoids legal and highly technical business terminology whenever possible; and

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(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(i) Uses a plain-language heading to call attention to the notice;

(ii) Uses a typeface and type size that are easy to read;

(iii) Provides wide margins and ample line spacing;

(iv) Uses boldface or italics for key words; and

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

(3) "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

(4) "Commissioner" means the insurance commissioner of the state.

(5) "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

(6) "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes and about whom the licensee has nonpublic personal information, or that individual's legal representative.

Examples.

(a) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if:

(i) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(ii) The individual is a claimant under an insurance policy issued by the licensee;

(iii) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(iv) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(v) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under WAC 284-04-400, 284-04-405, and 284-04-410.

(e) Provided that the licensee provides the initial, annual and revised notices under WAC 284-04-200, 284-04-205, and 284-04-220 to the plan sponsor, group or blanket insurance policy holder or group annuity contract holder, workers' compensation plan participant and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under WAC 284-04-400, 284-04-405, and 284-04-410, an individual is not the consumer of such licensee solely because he or she is:

(i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(ii) Covered under a group or blanket insurance policy or annuity contract issued by the licensee; or

(iii) A beneficiary in a workers' compensation plan.

(f) The individuals described in (e)(i) through (iii) of this subsection are consumers of a licensee if the licensee does not meet all the conditions of (e) of this subsection.

(g) In no event shall such individuals, solely by virtue of the status described in (e)(i) through (iii) of this subsection, be deemed to be customers for purposes of this chapter.

(i) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(ii) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

(7) "Consumer reporting agency" has the same meaning as in section 603(f) of the Federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

(8) "Control" means:

(a) Ownership, control or power to vote twenty-five percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(b) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(c) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

(9) "Customer" means a consumer who has a customer relationship with a licensee.

(10) "Customer relationship" means continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

Examples.

(a) A consumer has a continuing relationship with a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(i) The consumer applies for insurance but does not purchase the insurance;

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction;

(iii) The individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(vi) The customer's policy is lapsed, expired, paid up or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of state or federal authority or promotional materials;

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(viii) For the purposes of this chapter, if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(11) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(a) Financial institution does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

(ii) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as such institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

(12) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

(13) "Health care" means: Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(c) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

(14) "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law or a health care facility.

(15) "Health information" means any information or data, except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(a) The past, present or future physical, mental or behavioral health or condition of an individual;

(b) The provision of health care to an individual; or

(c) Payment for the provision of health care to an individual.

(16) "Insurer" includes health care service contractor, HMO, and fraternal benefit society.

(17) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

(18) "Licensee" means all licensed insurers, health care service contractors, HMO's, and fraternal benefit societies, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance law of this state.

(a) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in WAC 284-04-100 through 284-04-400 or the notice and policy development and implementation procedures of WAC 284-04-500 if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(i) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(ii) The licensee complies with the principal's privacy policies and does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

(b)(i) Subject to (b)(ii) of this subsection, "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to section [insert section] of this state's laws.

(ii) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in WAC 284-04-100 through 284-04-400 provided:

(A) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under WAC 284-04-405, except as permitted by WAC 284-04-410 and 284-04-415; and

(B) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW"

(19) "Licensee" shall also include an unauthorized insurer that places business through a licensed excess line broker in this state, but only in regard to the excess line placements placed pursuant to of this state's laws.

(20) "Nonaffiliated third party" means any person except:

(a) A licensee's affiliate; or

(b) A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4 (k)(4)(H) or insurance company investment activities of the type described in section 4 (k)(4)(I) of the Federal Bank Holding Company Act (12 U.S.C. 1843 (k)(4)(H) and (I).)

(21) "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

(22)(a) "Nonpublic personal financial information" means:

(i) Personally identifiable financial information; and

(ii) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(b) Nonpublic personal financial information does not include:

(i) Health information;

(ii) Publicly available information, except as included on a list described in (a)(i) of this subsection; or

(iii) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

Examples of lists.

Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

(23) "Nonpublic personal health information" means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(24) "Personally identifiable financial information" means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from any transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

Examples.

(i) Information included. Personally identifiable financial information includes:

(A) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(B) Account balance information and payment history;

(C) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(D) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(E) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(F) Any information the licensee collects through an internet "cookie" (an information collecting device from a web server); and

(G) Information from a consumer report.

(ii) Information not included. Personally identifiable financial information does not include:

(A) Health information;

(B) A list of names and addresses of customers of an entity that is not a financial institution; and

(C) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

(25)(a) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

- (i) Federal, state or local government records;
- (ii) Widely distributed media; or
- (iii) Disclosures to the general public that are required to be made by federal, state or local law.

(b) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(i) That the information is of the type that is available to the general public; and

(ii) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(c) Examples.

(i) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(ii) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(iii) Reasonable basis.

(A) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(B) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, Gramm-Leach-Bliley Act (Public Law 102-106) sections 501(b) and 505 (b)(2), 02-08-019 (Matter No. R 2001-12), § 284-04-120, filed 3/25/02, effective 4/25/02. Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2), 01-03-034 (Matter No. R 2000-08), § 284-04-120, filed 1/9/01, effective 2/9/01.]

PART 2 PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

WAC 284-04-200 Initial privacy notice to consumers required. (1) Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(a) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection (5) of this section; and

(b) Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by WAC 284-04-405 and 284-04-410;

(2) When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under subsection (1)(b) of this section if:

(a) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by WAC 284-04-405 and 284-04-410; and

The licensee does not have a customer relationship with the consumer; or

(b) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(3) When the licensee establishes a customer relationship.

(a) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(b) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(i) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(ii) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

(4) Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of subsection (1) of this section as follows:

(a) The licensee may provide a revised policy notice, under WAC 284-04-220, that covers the customer's new insurance product or service; or

(b) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection (1) of this section.

(5) Exceptions to allow subsequent delivery of notice.

(a) A licensee may provide the initial notice required by subsection (1)(a) of this section within a reasonable time after the licensee establishes a customer relationship if:

(i) Establishing the customer relationship is not at the customer's election; or

(ii) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(b) Examples of exceptions.

(i) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(ii) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a cus-

tomers relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(iii) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

(6) Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to WAC 284-04-225. If the licensee uses a short-form initial notice for noncustomers according to WAC 284-04-210(4), the licensee may deliver its privacy notice according to WAC 284-04-210 (4)(c).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2), 01-03-034 (Matter No. R 2000-08), § 284-04-200, filed 1/9/01, effective 2/9/01.]

WAC 284-04-205 Annual privacy notice to customers required.

(1)(a) General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(b) Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year one, the licensee shall provide an annual notice to that customer by December 31 of year two.

(2)(a) Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(b) Examples.

(i) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or obtains insurance services with or through the licensee.

(ii) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired, paid up or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

(iii) For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if sub-

sequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(iv) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

(3) Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-205, filed 1/9/01, effective 2/9/01.]

WAC 284-04-210 Information to be included in privacy notices. (1) General rule. The initial, annual and revised privacy notices that a licensee provides under WAC 284-04-200, 284-04-205, and 284-04-220 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(a) The categories of nonpublic personal financial information that the licensee collects;

(b) The categories of nonpublic personal financial information that the licensee discloses;

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(d) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under WAC 284-04-405 and 284-04-410;

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under WAC 284-04-400 (and no other exception in WAC 284-04-405 and 284-04-410 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(f) An explanation of the consumer's right under WAC 284-04-300(1) to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(g) Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the Federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(h) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(i) Any disclosure that the licensee makes under subsection (2) of this section.

(2) Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under WAC 284-04-405 and 284-04-410, the licensee is not required to list those exceptions in the initial or annual privacy notices required by WAC 284-04-200 and 284-04-205. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(3) Examples.

(a) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(i) Information from the consumer;

(ii) Information about the consumer's transactions with the licensee or its affiliates;

(iii) Information about the consumer's transactions with nonaffiliated third parties; and

(iv) Information from a consumer reporting agency.

(b) Categories of nonpublic personal financial information a licensee discloses.

(i) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in (a) of this subsection, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(A) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and social security number;

(B) Transaction information, such as information about balances, payment history, and parties to the transaction; and

(C) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(ii) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(iii) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(c) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(i) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(ii) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(iii) A licensee also may categorize the affiliates and nonaffiliated third parties to whom it discloses nonpublic personal financial information about consumers using more detailed categories.

(d) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in WAC 284-04-400 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subsection (1)(e) of this section if it:

(i) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subsection (1)(b) of this section, as applicable; and

(ii) States whether the third party is:

(A) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(B) A financial institution with whom the licensee has a joint marketing agreement.

(e) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under WAC 284-04-405 and 284-04-410, the licensee may simply state that fact, in addition to the information it shall provide under subsections (1)(h), (i) and (2) of this section.

(f) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(i) Describes in general terms who is authorized to have access to the information; and

(ii) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

(4) Short-form initial notice with opt out notice for non-customers.

(a) A licensee may satisfy the initial notice requirements in WAC 284-04-200 (1)(b) for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in WAC 284-04-215.

(b) A short-form initial notice shall:

(i) Be clear and conspicuous;

(ii) State that the licensee's privacy notice is available upon request; and

(iii) Explain a reasonable means by which the consumer may obtain that notice.

(c) The licensee shall deliver its short-form initial notice according to WAC 284-04-225. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to WAC 284-04-225.

(d) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(i) Provides a toll-free telephone number that the consumer may call to request the notice; or

(ii) For a consumer who conducts business in person at the licensee's office, maintain copies of the notice on hand that the licensee provides to the consumer immediately upon request.

(5) Future disclosures. The licensee's notice may include:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but do not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

(6) Sample clauses. Sample clauses illustrating some of the notice content required by this section are included in Appendix A of this regulation.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2), 01-03-034 (Matter No. R 2000-08), § 284-04-210, filed 1/9/01, effective 2/9/01.]

WAC 284-04-215 Form of opt out notice to consumers and opt out methods.

(1)(a) Form of opt out notice. If a licensee is required to provide an opt out notice under WAC 284-04-300(1), it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(i) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(ii) That the consumer has the right to opt out of that disclosure; and

(iii) A reasonable means by which the consumer may exercise the opt out right.

(b) Examples.

(i) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(A) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in WAC 284-04-210 (1)(b) and (c), and states that the consumer can opt out of the disclosure of that information; and

(B) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(ii) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(A) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Includes a reply form together with the opt out notice;

(C) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the

licensee's web site, if the consumer agrees to the electronic delivery of information; or

(D) Provides a toll-free telephone number that consumers may call to opt out.

(iii) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(A) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(B) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(iv) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

(2) Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with WAC 284-04-200.

(3) Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with WAC 284-04-200, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(4) Joint relationships.

(a) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in (e) of this subsection).

(b) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(i) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(ii) Permit each joint consumer to opt out separately.

(c) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(d) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(e) Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(i) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(ii) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(iii) Permit John and Mary to make different opt out directions. If the licensee does so:

(A) It shall permit John and Mary to opt out for each other;

(B) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(C) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

(5) Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(6) Continuing right to opt out. A consumer may exercise the right to opt out at any time.

(7) Duration of consumer's opt out direction.

(a) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(b) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(8) Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-215, filed 1/9/01, effective 2/9/01.]

WAC 284-04-220 Revised privacy notices. (1) General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under WAC 284-04-200, unless:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(b) The licensee has provided to the consumer a new opt out notice;

(c) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) Examples.

(a) Except as otherwise permitted by WAC 284-04-400, 284-04-405, and 284-04-410, a licensee shall provide a revised notice before it:

(i) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(ii) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(iii) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(b) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

(3) Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to WAC 284-04-225.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-220, filed 1/9/01, effective 2/9/01.]

WAC 284-04-225 Delivery. (1) How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(2)(a) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(i) Hand-delivers a printed copy of the notice to the consumer;

(ii) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(iii) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(iv) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(b) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(i) Only posts a sign in its office or generally publish advertisements of its privacy policies and practices; or

(ii) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(3) Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(a) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(4) Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

(5) Retention or accessibility of notices for customers.

(a) For customers only, a licensee shall provide the initial notice required by WAC 284-04-200 (1)(a), the annual notice required by WAC 284-04-205(1), and the revised notice required by WAC 284-04-220 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

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(b) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(i) Hand-delivers a printed copy of the notice to the customer;

(ii) Mails a printed copy of the notice to the last known address of the customer; or

(iii) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

(6) Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

(7) Joint relationships. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of WAC, respectively, by providing one notice to those consumers jointly.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-225, filed 1/9/01, effective 2/9/01.]

PART 3 LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

WAC 284-04-300 Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties.

(1)(a) Conditions for disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(i) The licensee has provided to the consumer an initial notice as required under WAC 284-04-200;

(ii) The licensee has provided to the consumer an opt out notice as required in WAC 284-04-215;

(iii) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(iv) The consumer does not opt out.

(b) Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by WAC 284-04-400, 284-04-405, and 284-04-410.

(c) Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(i) By mail. The licensee mails the notices required in (a) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty days from the date the licensee mailed the notices.

(ii) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices

required in (a) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(iii) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in (a) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(2) Application of opt out to all consumers and all non-public personal financial information.

(a) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(b) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

(3) Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-300, filed 1/9/01, effective 2/9/01.]

WAC 284-04-305 Limits on redisclosure and reuse of nonpublic personal financial information. (1)(a) Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in WAC 284-04-405 or 284-04-410, the licensee's disclosure and use of that information is limited as follows:

(i) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(ii) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(iii) The licensee may disclose and use the information pursuant to an exception in WAC 284-04-405 or 284-04-410, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(b) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

(2)(a) Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other

than under an exception in WAC 284-04-405 or 284-04-410, the licensee may disclose the information only:

(i) To the affiliates of the financial institution from which the licensee received the information;

(ii) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(iii) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(b) Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in WAC 284-04-405 or 284-04-410:

(i) The licensee may use that list for its own purposes; and

(ii) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in WAC 284-04-405 or 284-04-410, such as to the licensee's attorneys or accountants.

(3) Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in WAC 284-04-405 or 284-04-410 of this regulation, the third party may disclose and use that information only as follows:

(a) The third party may disclose the information to the licensee's affiliates;

(b) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(c) The third party may disclose and use the information pursuant to an exception in WAC 284-04-405 or 284-04-410 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(4) Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in WAC 284-04-405 or 284-04-410, the third party may disclose the information only:

(a) To the licensee's affiliates;

(b) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(c) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-305, filed 1/9/01, effective 2/9/01.]

WAC 284-04-310 Limits on sharing account number information for marketing purposes. (1) General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a con-

sumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

(2) Exceptions. Subsection (1) of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(b) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(c) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(3) Examples.

(a) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(b) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-310, filed 1/9/01, effective 2/9/01.]

PART 4

EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

WAC 284-04-400 Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing. (1) General rule.

(a) The opt out requirements in WAC 284-04-215 and 284-04-300 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(i) Provides the initial notice in accordance with WAC 284-04-200; and

(ii) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in WAC 284-04-405 or 284-04-410 in the ordinary course of business to carry out those purposes.

(b) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of (a)(ii) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in WAC 284-04-405 or

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284-04-410 in the ordinary course of business to carry out that joint marketing.

(2) Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under subsection (1) of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

(3) Definition of joint agreement. For purposes of this section, joint agreement means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor an insurance product or service.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-400, filed 1/9/01, effective 2/9/01.]

WAC 284-04-405 Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions.

(1) Exceptions for processing transactions at consumer's request. The requirements for initial notice in WAC 284-04-200 (1)(b), the opt out in WAC 284-04-215 and 284-04-300 and service providers and joint marketing in WAC 284-04-400 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(a) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(b) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(c) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(d) Reinsurance or stop loss or excess loss insurance.

(2) Necessary to effect, administer or enforce a transaction means that the disclosure is:

(a) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(b) Required, or is a usual, appropriate or acceptable method:

(i) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(ii) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(iii) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(iv) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(v) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a con-

sumer's insurance: Account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(vi) In connection with:

(A) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

(B) The transfer of receivables, accounts or interests therein; or

(C) The audit of debit, credit or other payment information.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-405, filed 1/9/01, effective 2/9/01.]

WAC 284-04-410 Other exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information. (1) Exceptions to opt out requirements. The requirements for initial notice to consumers in WAC 284-04-200 (1)(b), the opt out in WAC 284-04-215 and 284-04-300, and service providers and joint marketing in WAC 284-04-400 do not apply when a licensee discloses nonpublic personal financial information:

(a) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(b)(i) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

(ii) To protect against or prevent actual or potential fraud or unauthorized transactions;

(iii) For required institutional risk control or for resolving consumer disputes or inquiries;

(iv) To persons holding a legal or beneficial interest relating to the consumer; or

(v) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(c) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(d) To the extent specifically permitted or required under other provisions of law and in accordance with the Federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission), the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commis-

sion), self-regulatory organizations or for an investigation on a matter related to public safety;

(e)(i) To a consumer reporting agency in accordance with the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

(ii) From a consumer report reported by a consumer reporting agency;

(f) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit; or

(g)(i) To comply with federal, state or local laws, rules and other applicable legal requirements;

(ii) To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

(iii) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(h) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

(2) Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under WAC 284-04-215(6).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-410, filed 1/9/01, effective 2/9/01.]

PART 5 RULES FOR HEALTH INFORMATION

WAC 284-04-500 Health information privacy policies and procedures. All licensees shall develop and implement written policies, standards and procedures for the management of health information, including policies, standards and procedures to guard against the unauthorized collection, use or disclosure of nonpublic personal health information by the licensee consistent with regulations adopted by the U.S. Department of Health and Human Services governing health information privacy (45 CFR 160 through 164) which shall include:

(1) Limitation on access to health information by only those persons who need to use the health information in order to perform their jobs;

(2) Appropriate training for all employees;

(3) Disciplinary measures for violations of the health information policies, standards and procedures;

(4) Identification of the job titles and job descriptions of persons that are authorized to disclose nonpublic personal health information;

(5) Procedures for authorizing and restricting the collection, use or disclosure of nonpublic personal health information;

(6) Methods for exercising the right to access and amend incorrect nonpublic personal health information;

(7) Methods for handling, disclosing, storing and disposing of health information;

(8) Periodic monitoring of the employee's compliance with the licensee's policies, standards and procedures in a manner sufficient for the licensee to determine compliance and to enforce its policies, standards and procedures; and

(9) Methods for informing and allowing an individual who is the subject of nonpublic personal health information to request specialized disclosure or nondisclosure of nonpublic personal health information as required in this chapter.

(10) A licensee shall make the health information policies, standards and procedures developed pursuant to this section available for review by the commissioner.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-500, filed 1/9/01, effective 2/9/01.]

WAC 284-04-505 Nonpublic personal health information—When authorization required. (1) A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

(2) Except as provided in WAC 284-04-510, nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of insurance functions by or on behalf of the licensee, for activities permitted under RCW 70.02.050, and for activities permitted under health privacy regulations adopted by the U.S. Department of Health and Human Services governing health information privacy.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-505, filed 1/9/01, effective 2/9/01.]

WAC 284-04-510 Right to limit disclosure of health information. (1) Notwithstanding other provisions of this chapter, a licensee shall limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this subsection shall be limited consistent with the individual's request, such as a request for the licensee to not release any information to a spouse to prevent domestic violence.

(2) Notwithstanding any insurance law requiring the disclosure of information, a licensee shall not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or certificateholder, if the individual who is the subject of the information makes a written request. In addition, a licensee shall not require an adult individual to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim.

(3)(a) A licensee shall recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and

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(b) Shall not disclose any nonpublic personal health information related to any health care service to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person, without the express authorization of the minor. In addition, a licensee shall not require the minor to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.

(4) When requesting nondisclosure, the individual shall include in the request:

(a) Their name and address;

(b) Description of the type of information that should not be disclosed;

(c) In the case of reproductive health information, the type of services subject to nondisclosure;

(d) The identity or description of the types of persons from whom information should be withheld;

(e) Information as to how payment will be made for any benefit cost sharing;

(f) A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-510, filed 1/9/01, effective 2/9/01.]

WAC 284-04-515 Authorizations. (1) A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(a) The identity of the consumer or customer who is the subject of the nonpublic personal health information.

(b) A general description of the types of nonpublic personal health information to be disclosed.

(c) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used.

(d) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed.

(e) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making such a revocation.

(2) An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

(3) A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of any individual who acted in reliance on the authorization prior to notice of the revocation.

(4) A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

(5) Notwithstanding the provisions of this section, a licensee complying with regulations adopted by the U.S. Department of Health and Human Services governing authorization for the release of health information satisfies the provisions of this section.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-515, filed 1/9/01, effective 2/9/01.]

WAC 284-04-520 Authorization request delivery. A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to WAC 284-04-225, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to WAC 284-04-500(1).

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-520, filed 1/9/01, effective 2/9/01.]

WAC 284-04-525 Relationship to state and federal laws. In the event of a conflict between this chapter and the state or federal laws, licensees shall comply with the state and federal laws governing privacy, as such laws relate to the business of insurance, except as expressly required by this chapter.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-525, filed 1/9/01, effective 2/9/01.]

PART 6 ADDITIONAL PROVISIONS

WAC 284-04-600 Protection of Fair Credit Reporting Act. Nothing in this regulation shall be construed to modify, limit or supersede the operation of the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under section 603 of that act.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-600, filed 1/9/01, effective 2/9/01.]

WAC 284-04-605 Nondiscrimination. (1) A licensee shall not discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

(2) A licensee shall not discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-605, filed 1/9/01, effective 2/9/01.]

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WAC 284-04-610 Violation. A violation of this regulation shall be deemed to be an unfair method of competition or an unfair or deceptive act and practice in this state.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-610, filed 1/9/01, effective 2/9/01.]

WAC 284-04-615 Severability. If any section or portion of a section of this regulation or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-615, filed 1/9/01, effective 2/9/01.]

WAC 284-04-620 Effective date; transition rule. (1) Effective date. These rules are effective July 1, 2001.

(2)(a) Notice requirement for consumers who are the licensee's customers on the compliance date. By July 1, 2001, a licensee shall provide an initial notice, as required by WAC 284-04-200, to consumers who are the licensee's customers on July 1, 2001.

(b) Example. A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

(3) Two-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of WAC 284-04-400 (1)(a)(ii), even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before January 9, 2001.

(4) With respect to nonpublic personal health information under WAC 284-04-510, these rules are effective December 30, 2002.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-620, filed 1/9/01, effective 2/9/01.]

APPENDIX A

WAC 284-04-900 Sample clauses. Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the Federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to non-affiliated third parties.)

A-1—Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(a) to describe the cate-

gories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2—Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of WAC 284-04-210 (1)(b) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premiums, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described (describe location in the notice, such as "above" or "below").

A-3—Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of WAC 284-04-210 (1)(b), (c), and (d) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4—Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(c) to describe the categories of affiliates and nonaffiliated third parties to whom the

licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410, as well as when permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as (provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents");
- Nonfinancial companies, such as (provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"); and
- Others, such as (provide illustrative examples, such as "nonprofit organizations").

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5—Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of WAC 284-04-210 (1)(e) related to the exception for service providers and joint marketers in WAC 284-04-400. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with whom the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as (provide illustrative examples, such as "your name, address, Social Security number, assets, income, and beneficiaries");
- Information about your transactions with us, our affiliates or others, such as (provide illustrative examples, such as "your policy coverage, premium, and payment history"); and
- Information we receive from a consumer reporting agency, such as (provide illustrative examples, such as "your creditworthiness and credit history").

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described (describe location in the notice, such as "above" or "below") to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6—Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(f) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted

ted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may (describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)").

A-7—Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(h) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to (provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"). We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

[Statutory Authority: RCW 48.43.505 and Gramm-Leach Bliley Act Public Law 102-106, sec. 501(b), sec. 505 (b)(2). 01-03-034 (Matter No. R 2000-08), § 284-04-900, filed 1/9/01, effective 2/9/01.]

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.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-05-070	Effective date. [Order R-72-1, § 284-05-070, filed 2/8/72, effective 7/1/72.] Repealed by 98-11-089 (Matter No. R 98-8), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060 and 48.92.140.
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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

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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 is represented in the instrument to be an actuary unless the person signing as an actuary is a qualified actuary.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 98-11-089 (Matter No. R 98-8), § 284-05-040, filed 5/20/98, effective 6/20/98; 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.

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:

- (1) Is a member of the American Academy of Actuaries; or
- (2) 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.

[Statutory Authority: RCW 48.02.060 and 48.92.140. 98-11-089 (Matter No. R 98-8), § 284-05-060, filed 5/20/98, effective 6/20/98; 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.]

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 Financial 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 work-papers.
284-07-220	Exemptions and effective dates.
284-07-230	Canadian and British companies.

ACTUARIAL OPINION AND MEMORANDUM REGULATION

284-07-310	Purpose.
284-07-320	Authority.
284-07-330	Scope.
284-07-340	Definitions.
284-07-350	General requirements.
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 and regulatory asset adequacy issues summary.
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.
284-07-360	Required opinions. [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.] Repealed by 08-01-077 (Matter No. R 2006-10), filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060, 48.74.-025, 48.36A.250, 48.36A.260.
284-07-370	Statement of actuarial opinion not including an asset adequacy analysis. [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.] Repealed by 08-01-077 (Matter No. R 2006-10), filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060, 48.74.-025, 48.36A.250, 48.36A.260.

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 provided by the commissioner.

(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) If an insurer has no data or experience to report, it is not required to submit a report.

(5) 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, 48.05.380, and 48.30.390. 03-03-133 (Matter No. R 2002-09), § 284-07-010, filed 1/22/03, effective 2/22/03. 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 Financial statement instructions.

(1) For the purpose of this section, the following definitions shall apply:

(a) "Insurer" shall have the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW, and fraternal benefit societies registered under chapter 48.36A RCW.

(b) "Insurance" shall have the same meaning as set forth in RCW 48.01.040. It also includes prepayment of health care services as set forth in RCW 48.44.010(3) and prepayment of comprehensive health care services as set forth in RCW 48.46.020(1).

(2) Each authorized insurer is required to file with the commissioner an annual statement for the previous calendar year in the general form and context as promulgated by the National Association of Insurance Commissioners (NAIC) for the kinds of insurance to be reported upon, and shall also file a copy thereof with the NAIC. To effectuate RCW 48.05.250, 48.05.400, 48.36A.260, 48.44.095 and 48.46.080 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.

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

(4) Annual statements:

(a) Annual statements for all domestic insurers must be filed electronically with the commissioner. Insurers must electronically transmit the annual statement, as described in subsection (2) of this section, in PDF or other format as noted on the commissioner's web site. The commissioner has the discretion to allow an insurer to file annual statements on paper. The insurer must demonstrate that filing in electronic form will create an undue financial hardship for the insurer. Applications for permission to file on paper must be received by the commissioner at least ninety days before the annual statement is due.

(b) To comply with statutory requirements that annual statements must be verified by the oaths of at least two of the insurer's officers, insurers may:

(i) Use a method of electronic signature verification that has been approved by the commissioner for use by the insurer; or

(ii) File a paper copy of the signature and jurat page of the annual statement at the time of the electronic filing of the annual statement. This paper copy must contain the original signature of the company officers and the notary administering the oath.

(c) Both the electronic annual statement and the verification of that statement by the oaths of two officers must be received by the commissioner to complete an annual statement filing. The date of receipt of the later of the electronic annual statement or verification is considered the receipt date of the annual statement.

(5)(a) Each domestic insurer shall file quarterly statements of its financial condition with the commissioner and with the NAIC. Each foreign insurer shall file quarterly statements of its financial condition with the NAIC. The commissioner may require a foreign insurer to file quarterly statements with the commissioner whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the foreign insurer. The statements shall be filed in the commissioner's office not later than the forty-fifth day or the fifteenth day of the second month after the end of the insurer's calendar quarters, whichever is later. The quarterly statements shall be in the form and content as promulgated by the NAIC for quarterly reporting by insurers, shall be prepared according to appropriate Annual and Quarterly Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC and shall be supplemented with additional information required by this title and by the commissioner. Quarterly statements for the fourth quarter are not required.

(b) Quarterly statements must be filed with the commissioner by electronically transmitting the quarterly statement as described in this subsection, in PDF or other format as noted on the commissioner's web site.

(6) As a part of any investigation by the commissioner, the commissioner may require an insurer to file monthly financial statements whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the insurer. Monthly financial statements 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 statement is being filed. Such monthly financial statements shall be the internal financial statements of the company. In addition, the commissioner may require these internal financial statements to be 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 designation as the insurer's quarterly financial statements of insurers. "Financial statements" as used in this subsection includes:

- (a) Statement of assets;
- (b) Liabilities, capital and surplus;
- (c) Statements of revenue and expenses; and
- (d) Statements of cash flows.

(7) Health care service contractors shall use the Health Statement Form promulgated by the NAIC for their statutory filings.

(8) Each health care service contractor's and health maintenance organization's annual statement shall be accompanied by an additional data statement form (IC-13A-HC/IC-14-HMO).

(9) The commissioner may allow a reasonable extension of the time for filing the financial statements. A request for an extension must be in writing. The request must be received prior to the due date of the filing and must state good cause for the extension. An extension can only be granted in writing; paper, fax, or e-mail is considered "writing" for purposes of this subsection.

[Statutory Authority: RCW 48.02.060, 48.44.500, and 48.46.200. 07-14-104 (Matter No. R 2007-04), § 284-07-050, filed 7/2/07, effective 8/2/07. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-050, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.05.073, 48.44.050, 48.46.200. 01-11-077 (Matter No. R 2000-09), § 284-07-050, filed 5/15/01, effective 6/15/01. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 99-16-035 (Matter No. R - 99-3), § 284-07-050, filed 7/28/99, effective 8/28/99; 96-17-079 (Matter No. R 95-18), § 284-07-050, filed 8/21/96, effective 9/21/96. 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 health care service contractors registered under chapter 48.44 RCW, health maintenance organizations registered under chapter 48.46 RCW, and fraternal benefit societies registered under chapter 48.36A RCW.

(2)(a) 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, or as defined in subsection (5) of this section for health care service contractors and health maintenance organizations 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.

(b) After December 31, 2002, statements of actuarial opinion for all domestic and foreign insurers must be filed electronically with the commissioner. This includes the statement of actuarial opinion for the year ended December 31, 2002. Insurers must electronically transmit the statement of actuarial opinion, as described in (a) of this subsection, in PDF or other format as noted on the commissioner's web site. The commissioner has the discretion to allow an insurer to file a statement of actuarial opinion on paper. The insurer must demonstrate that filing in electronic form will create an undue financial hardship for the insurer. Applications for per-

mission to file a paper copy must be received by the commissioner at least ninety days before the statement of actuarial opinion is due.

(c) To comply with requirements that statements of actuarial opinion must be signed by the actuary, an insurer may:

(i) Use a method of electronic signature verification that has been approved by the commissioner for use by the insurer; or

(ii) File a paper copy of the signature page of the statement of actuarial opinion at the time of the electronic filing of the statement of actuarial opinion. The paper copy must contain the original signature of the actuary.

(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*.

(5) With respect to statements of actuarial opinion for health care service contractors and health maintenance organizations, the qualified actuary must be:

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

(b) A person recognized by the American Academy of Actuaries as qualified for such actuarial evaluation; 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. In such a case, the health care service contractor or health maintenance organization must request approval at least ninety days prior to the filing of its annual statement.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-060, filed 10/23/02, effective 11/23/02. 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) For the purpose of this section, the following definition shall apply: "Insurer" shall have the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW, health maintenance organizations registered under chapter 48.46

RCW, and fraternal benefit societies registered under chapter 48.36A RCW.

(2) Annual statements, quarterly statements, and other financial reports filed by an insurer with the commissioner or the National Association of Insurance Commissioners shall be filed in electronic form as well as on paper through December 31, 2002. All annual, quarterly, and other financial statements filed by an insurer after December 31, 2002, shall be filed with the commissioner in electronic form only according to WAC 284-07-050.

(3) Until the commissioner otherwise directs by letter, bulletin, or otherwise, generally or as to one or more companies, "electronic form" means, on a diskette, internet filing, or File Transfer Protocol (FTP) filing, for all filings made prior to January 1, 2003. For all filings required to be made on or after January 1, 2003, "electronic form" will exclude diskette.

(4) An insurer who on December 31, 1996, was not subject to this rule or has not previously filed in electronic form to the commissioner or the NAIC, shall comply with this rule for the year ending December 31, 1996, and each year thereafter. To enhance the intrastate and interstate surveillance of the insurer's financial condition earlier filing is permitted.

(5) The requirement under this section applies to the extent that the NAIC has issued a diskette submission directive or has otherwise approved or prescribed an applicable diskette format for the particular class of insurer.

(6) The commissioner may allow a reasonable extension of the time for filing the financial statements. A request for an extension must be in writing. The request must be received prior to the due date of the filing and must state good cause for the extension. An extension can only be granted in writing; paper, fax, or e-mail is considered "writing" for purposes of this subsection.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-070, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 96-17-079 (Matter No. R 95-18), § 284-07-070, filed 8/21/96, effective 9/21/96. 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 require-

ment 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 NAIC 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 NAIC 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.

(5) After January 1, 2003, all reports and filings required by WAC 284-07-100 through 284-07-230 must be filed electronically with the commissioner. Insurers must electronically transmit the report or filing in PDF or other format as noted on the commissioner's web site. The commissioner has the discretion to allow an insurer to file paper copies of reports and filings required by WAC 284-07-100 through 284-07-230. The insurer must demonstrate that filing in electronic form will create an undue financial hardship for the insurer. Applications for permission to file in hard copy must be received by the commissioner at least ninety days before the statement of annual statement is due.

(6) To comply with statutory or other requirements that reports or filings be signed or verified, insurers and accountants may:

(a) Use a method of electronic signature verification that has been approved by the commissioner; or

(b) File a paper copy of the signature or verification at the time of the electronic transmission of the report or filing.

(7) The report or filing and the appropriate signatures and/or verifications must both be received to complete a filing. The date of receipt of the later of the two parts of the filing is considered the receipt date of the report or filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 06-16-093 (Matter No. R 2006-06), § 284-07-100, filed 7/31/06, effective 8/31/06; 02-21-120 (Matter No. R 2002-07), § 284-07-100, filed 10/23/02, effective 11/23/02. 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 health care service contractors

registered under chapter 48.44 RCW, health maintenance organizations registered under chapter 48.46 RCW, and fraternal benefit societies registered under chapter 48.36A RCW.

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

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

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-110, filed 10/23/02, effective 11/23/02. 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 *NAIC Accounting Practices and Procedures Manual*. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to RCW 48.05.250, 48.05.073, 48.36A.260, 48.43.050, 48.43.097, 48.44.095, or 48.46.080 with a written description of the nature of these differences.

(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, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-130, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.05.073, 48.43.097, 48.44.050, 48.46.200. 01-21-075 (Matter No. R 2001-03), § 284-07-130, filed 10/18/01, effective 11/18/01. 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 RCW, 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 account-

tant 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 applica-

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tion, 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

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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.]

ACTUARIAL OPINION AND MEMORANDUM REGULATION

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

(1) Guidelines and standards for statements of actuarial opinion submitted in accordance with the requirements of RCW 48.74.025, 48.36A.250, 48.36A.260, and for supporting memoranda;

(2) Rules applicable to the appointment of an appointed actuary; and

(3) Guidelines and standards relating to "adequacy of reserves."

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-310, filed 12/17/07, effective 1/17/08. 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. This regulation requires the appointed actuary to use his or her professional judgment in performing the required asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. The commissioner may specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's opinion, such specifications are necessary.

(2) This regulation applies to all annual statements filed with the commissioner on and after December 31, 2007.

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-330, filed 12/17/07, effective 1/17/08. 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.]

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WAC 284-07-340 Definitions. The following definitions apply throughout this regulation:

(1) "Actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis set forth in WAC 284-07-380 and according to applicable actuarial standards of practice.

(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 set forth in WAC 284-07-350(4).

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

(7) "Qualified actuary" means an individual who meets the requirements set forth in WAC 284-07-350(1).

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-340, filed 12/17/07, effective 1/17/08. 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. The 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, are required each year.

Statement of actuarial opinion:

(1) "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 incompetence, 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.

(2) "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.

(a) The company shall give the commissioner timely written notice of the following: 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.

(b) The company must state in its notice that the appointed actuary meets the requirements set forth in subsection (1) of this section.

(c) After the company furnishes the notice, no further notice is required with respect to this person, except the following, if applicable:

(i) The company must give the commissioner timely written notice if the actuary ceases to be appointed or retained as an appointed actuary; and

(ii) The company must give the commissioner timely written notice if the actuary fails to meet the requirements set forth in subsection (2) of this section.

(d) If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice must include that information and give the reasons for replacement.

(3) Standards for asset adequacy analysis: Unless the commissioner approves equivalents in advance, the asset adequacy analysis required by this regulation:

(a) Must 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, and must form the basis of the statement of actuarial opinion in accordance with this regulation; and

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

(4) Liabilities to be covered:

(a) As required by RCW 48.74.025, the statement of actuarial opinion applies to all in force business on the statement date regardless of when or where issued, including reserves of Exhibits 5, 6, and 7, and claim liabilities in Exhibit 8, 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 calculated in accordance with methods set forth in RCW 48.74.040, 48.74.070, 48.74.080, and 48.74.090, the company must establish the appropriate additional reserve.

(c) Additional reserves established under (b) 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 these reserves will not be deemed an adoption of a lower standard of valuation.

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-350, filed 12/17/07, effective 1/17/08. 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 284-07-380 Statement of actuarial opinion based on an asset adequacy analysis. (1) General description: The statement of actuarial opinion must include the following:

(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 expert relied on in the form prescribed by subsection (5) of this section; and

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

(e) One or more of the following paragraphs will be needed 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 an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(iv) 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

(v) 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 must 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 must clearly express his or her professional judgment. In any event, the opinion must include all pertinent aspects of the language provided in this section.

(a) The opening paragraph must generally state 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 must 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 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."

(ii) For a consulting actuary, the opening paragraph must 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 must 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, 20[]. 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 5					
A Life Insurance					
B Annuities					
C Supplementary Contracts With Life Contingencies					
D Accidental Death Benefit					
E Disability - Active					
F Disability - Disabled					
G Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6					
A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7					
Premiums and Other Deposit Funds (Column 6, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Annuities Certain (Column 3, Line 14)					
Supplemental Contracts (Column 4, Line 14)					
Dividend Accumulations or Refunds (Column 5, Line 14)					
Total (Exhibit 7, Item 3, Page 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)
Exhibit 8 Part 1					
1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1 and 2)					
TOTAL RESERVES					

IMR (General Account, Page 3, Line 9.4)	
IMR (Separate Accounts, Page 3, Line 3)	
AVR (Page 3, Line 24.1)	(c)
Net Deferred and Uncollected Premium	

[exhibits and schedules listed as applicable] of the company's current annual statement."

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

"In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects my examination included review of the actuarial assumptions and actuarial methods used and tests of the actuarial calculations I considered necessary."

The paragraph must be accompanied by a signed statement by each person relied upon based on the form set forth in subsection (5) of this section.

(f) The opinion paragraph must 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);

Notes to table of reserves and related actuarial items:

Page and line numbers refer to the 2005 blank. Corresponding entries from blanks from later years are to be substituted as appropriate.

- (a) The additional actuarial reserves are the reserves established under WAC 284-07-350 (5)(b).
- (b) The appointed actuary must state 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 of Asset Valuation Reserve (AVR)."

(c) If the appointed actuary has relied on other experts to develop any portion of the analysis, the reliance paragraph must include a statement substantially similar to the following:

"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, or certain critical aspects of the analysis performed in conjunction with forming my opinion] as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts must be accompanied by a statement by each expert in 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 must also include substantially the following statement:

"My examination included a review of the actuarial assumptions, actuarial methods, the underlying basic asset and liability records, and other tests of the actuarial calculations I considered necessary. I also reconciled the underlying basic asset and liability records to

- (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 the assets, and the considerations anticipated to be received and retained under the 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.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date"

(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.

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

(5) Reliance on data furnished by other persons: If the appointed actuary does not express an opinion as to the accu-

racy and completeness of the listings and summaries of policies in force or if the actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion must include the names of the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies must provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness of the items, as applicable. This certification must include the signature, title, company's legal name, address and telephone number of the person providing the certification, and the date on which it is signed. This certification must include the reporting date, the name of the appointed actuary, and must be attached to the opinion, in a form substantially similar to the following:

"I [name of officer], [title], of [name of company], hereby affirm that the listings and summaries of policies and contracts in force as of December 31, 20[], 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.

Signature of the Officer of the Company

Address of the Officer of the Company

Telephone Number of the Officer of the Company

Date"

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260. 08-01-077 (Matter No. R 2006-10), § 284-07-380, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060. 06-12-077 (Matter No. R 2006-04), § 284-07-380, filed 6/6/06, effective 7/7/06. 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.]

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

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

(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 must include a statement to that effect in their memoranda.

(c) If the commissioner requests a memorandum and an adequate memorandum is not provided within ten days after 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 must be paid by the company but all expenses related to the review will be directed and controlled by the commissioner.

(d)(i) The reviewing actuary must 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 must be retained by the commissioner. Information provided by the company to the reviewing actuary and included in the work papers will be considered material provided by the company to the commissioner and will be kept confidential to the same extent as prescribed by law with respect to other material provided by the company to the commissioner.

(ii) The reviewing actuary must not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the company for the current year or any one of the preceding three years.

(e) In accordance with RCW 48.74.025, the appointed actuary must prepare a regulatory asset adequacy issues summary according to the requirements set forth in subsection (3) of this section. The regulatory asset adequacy issues summary must be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. Except for a domestic life insurance company, the regulatory asset adequacy issues summary must be submitted only upon request of the commissioner. The regulatory asset adequacy issues summary has the standing of a memorandum in support of the actuarial opinion, and will be kept confidential to the extent and under the conditions provided for in RCW 48.74.025(4).

(2) When an actuarial opinion is provided, the memorandum must demonstrate that the analysis has been completed in accordance with the standards for asset adequacy set forth in WAC 284-07-350(4) and any additional standards required by the commissioner. The memorandum must include the following:

- (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;
 - (vi) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;
 - (vii) Documentation of assumptions, including comparisons with experience, to test reserves for the following:
 - (A) Lapse rates, both base and excess;
 - (B) Interest crediting rate strategy;

- (C) Mortality;
- (D) Policyholder dividend strategy;
- (E) Competitor or market interest rate;
- (F) Annuitization rates;
- (G) Commissions and expenses; and
- (H) Morbidity.

The documentation of the assumptions must allow an actuary reviewing the actuarial memorandum to form a conclusion regarding the reasonableness of the assumptions.

(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;
- (v) Documentation of assumptions made for:
 - (A) Default costs;
 - (B) Bond call function;
 - (C) Mortgage prepayment function;
 - (D) Determining market value for assets sold due to disinvestment strategy; and
 - (E) Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions must allow an actuary reviewing the actuarial memorandum to form a conclusion regarding the reasonableness of the assumptions.

(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, including the level of "materiality" that was used in determining how rigorously to analyze different blocks of business;
- (iv) Criteria for determining asset adequacy, including the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions, as specified in relevant actuarial standards of practice;
- (v) Consideration of the impact of federal income taxes; and

(vi) The method of treating reinsurance in the asset adequacy analysis.

(d) Sensitivity testing: Impact of changes in assumptions used in asset adequacy analysis, based on sensitivity tests performed.

(e) Material changes: Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis.

(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; and
- (ii) Summary of results.

(g) Conclusion(s).

(3) The regulatory asset adequacy issues summary must contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and must be signed and dated by the appointed actuary providing the actu-

arial opinion. The regulatory asset adequacy issues summary must include all of the following:

(a) Descriptions of the scenarios tested, including whether those scenarios are stochastic or deterministic, and the sensitivity testing performed relative to those scenarios.

(i) If certain tests produce negative ending surplus in the aggregate, the actuary must describe those tests and state the amount of additional reserve as of the valuation date that, if held, would eliminate the negative aggregate surplus values.

(ii) The actuary must determine ending surplus values by either:

(A) Extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial; or

(B) Adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(b) An explanation of the extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis.

(c) A description of the amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion.

(d) Comments on any interim results that may be of significant concern to the appointed actuary.

(e) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

(f) A paragraph explaining whether the actuary is satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(4) The memorandum must 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 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 48.01-077 (Matter No. R 2006-10), § 284-07-390, filed 12/17/07, effective 1/17/08. 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 man-

aged 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 consistent 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 284-12 WAC

AGENTS, BROKERS AND ADJUSTERS

WAC

- 284-12-080 Requirements for separate accounts.
- 284-12-090 When general agent may accept applications from non-appointed agents.
- 284-12-095 Unfair practice with respect to use of general agent defined.
- 284-12-110 Identification of agent or solicitor to prospective insured.

MANAGING GENERAL AGENTS

- 284-12-200 Operating in this state.
- 284-12-210 Affiliates.
- 284-12-220 Licensed in this state.
- 284-12-230 Notification of appointment.
- 284-12-250 Employee.
- 284-12-260 Form of financial statements.
- 284-12-270 Expiration and renewal of appointments.
- 284-12-280 Claim thresholds.

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 record-keeping 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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284-13-110 Purpose. [Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-110, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.-060, 48.05.250 and 48.05.400.
284-13-120 Scope. [Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-120, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.-060, 48.05.250 and 48.05.400.
284-13-130 Accounting requirements. [Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-130, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
284-13-140 Written agreements. [Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-140, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
284-13-150 Existing agreements. [Statutory Authority: RCW 48.02.060. 87-09-056 (Order R 87-4), § 284-13-150, filed 4/20/87.] Repealed by 95-19-018 (Order 95-4), filed 9/8/95, effective 10/9/95. Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400.
284-13-310 Definitions. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-13-320 RBC reports. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
284-13-330 Company action level event. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.

- 284-13-340 Regulatory action level event. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-13-350 Authorized control level event. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-13-360 Mandatory control level event. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-13-370 Hearings. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-380 Confidentiality and prohibition on announcements. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-390 Supplemental provisions. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-13-400 Foreign and alien insurers. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 284-13-410 Notices. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.
- 284-13-420 Phase-in provision. [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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

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.]

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 284-13-505 Actual reinsurance. Ceding insurers, have at times, entered into reinsurance agreements primarily as financing arrangements which have the principle purpose of producing increased surplus for the ceding insurer, typically on a temporary basis, but which provide little or no indemnification of insurance risks by the reinsurer. Credit for reinsurance shall not be allowed in any accounting or financial statement of the ceding insurer in respect to any so-called reinsurance contract unless, in such contract, the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance. This section shall only apply to those reinsurance contracts entered into after December 31, 1996.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-505, filed 2/10/97, effective 3/13/97.]

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 284-13-515 Qualified United States financial institution. A qualified United States financial institution means an institution that:

- (1) Is organized or, in the case of a U.S. office of a foreign banking organization, licensed under the laws of the United States or any state thereof;
- (2) Is regulated, supervised, and examined by U.S. federal or state authorities having regulatory authority over banks and trust companies;
- (3) Has been designated by the Securities Valuation Office of the National Association of Insurance Commissioners as meeting its credit standards for issuing or confirming letters of credit; and
- (4) Is not affiliated with the assuming company.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-515, filed 2/10/97, effective 3/13/97.]

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

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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 financial institution as provided in WAC 284-13-515, 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 incorporated and unincorporated underwriters shall consist of:

(a) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, funds in trust in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled insurers to any member of the group;

(b) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this regulation, funds in trust in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(c) 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 for all years of account. 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 credit allowed for reinsurance shall not be greater than the amount of funds held in trust.

(4) The trust established shall comply with WAC 284-13-535.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-520, filed 2/10/97, effective 3/13/97. 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 284-13-530 Credit for reinsurance—Certain alien reinsurers maintaining trust funds. (1) Under RCW 48.12.160 (1)(b), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to a single assuming alien insurer which, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount not less than the assuming alien insurer's liabilities attributable to reinsurance ceded by United States domiciled insurers plus maintain a trustee surplus of not less than twenty million dollars, and the assuming alien insurer maintaining the trust fund has received a registration from the commissioner. The assuming alien insurer shall report on or before February 28 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. To be registered the assuming alien insurer must:

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(a) File a properly executed Form AR-1 under WAC 284-13-595 as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records under chapter 48.03 RCW.

(b) File with the commissioner a certified copy of a letter or a certificate of authority or of compliance issued by the assuming alien insurer's alien domiciliary jurisdiction and the domiciliary jurisdiction of its United States reinsurance trust.

(c) File with the commissioner within sixty days after its financial statements are due to be filed with its domiciliary regulator, a copy of the assuming alien insurer's annual financial report converted to United States dollars, and a copy of its most recent audited financial statement converted to United States dollars.

(d) File annually with the commissioner on or before February 28, a statement of actuarial opinion in conformance with the NAIC's annual statement and instructions attesting to the adequacy of the reserves for United States liabilities which are backed by the trust fund. Unless the commissioner notifies the assuming alien insurer otherwise, the opinion may be given by an actuary of the assuming alien insurer, who is duly qualified to provide actuarial opinions in the domiciliary jurisdiction of the assuming alien insurer.

(e) File and maintain with the commissioner a list of the assuming alien insurer's United States reinsurance intermediaries.

(f) File and maintain with the commissioner copies of service and management agreements, including binding authorities, entered into by the assuming alien insurer.

(g) File annually with the commissioner a holding company registration statement containing the information required by RCW 48.31B.025 (2)(a) through (e) in the form proscribed in WAC 284-18-920.

(h) File annually with the commissioner the assuming alien insurer's account and report which reports the overall business of the assuming alien insurer in United States dollars.

(i) File other information, financial or otherwise, which the commissioner reasonably requests.

(2) If the commissioner determines that the assuming alien insurer has failed to meet or maintain any of these qualifications, the commissioner may, consistent with chapters 48.04 and 34.05 RCW, revoke the registration of the assuming insurer maintaining the trust fund. No credit shall be allowed a domestic ceding insurer with respect to reinsurance ceded after December 31, 1997, if the assuming alien insurer's registration under this section has been denied or revoked by the commissioner.

(3) The required amount of the trust shall be based upon the gross United States liabilities, including incurred but not reported claims (IBNR), of the assuming alien insurer reduced only for those liabilities for which specific collateralization has been provided to individual ceding companies, with such adjustments, if any, as the commissioner may from time to time consider appropriate.

(4) The credit allowed for reinsurance shall not be greater than the amount of funds held in trust.

(5) The trust established shall comply with WAC 284-13-535.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-530, filed 2/10/97, effective 3/13/97.]

WAC 284-13-535 Trust fund requirements. The trust under RCW 48.12.160 (1)(a), (b) or (c)(i) shall be established in a form filed with and approved by the commissioner and complying with that statute and this section. The trust instrument shall provide that:

(1) 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.

(2) 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.

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

(4) 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.

(5) 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.

(6) Furnish to the commissioner 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.

(7) At least sixty days, but not more than one hundred twenty days, prior to termination of the trust, written notification of termination shall be delivered by the trustee to the commissioner.

(8) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by RCW 48.12.160, WAC 284-13-520 and 284-13-530 or if the grantor(s) of the trust has been declared insolvent or placed in receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of insurance companies. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor(s) of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(9) No amendment to the trust shall be effective unless:

(a) It has been reviewed and approved in advance by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust; and

(b) It has been filed with the commissioner and it has not been disapproved within thirty days of its receipt by the commissioner.

(10) The form of the trust and any amendments to the trust shall also be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-535, filed 2/10/97, effective 3/13/97.]

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)(c), the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall not be greater than 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 a qualified United States financial institution as defined in WAC 284-13-515 subject to withdrawal solely by, and under the exclusive control of, the ceding insurer. 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 WAC 284-13-515, 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 284-13-560 are met.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-540, filed 2/10/97, effective 3/13/97. 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).

(2009 Ed.)

(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 alien insurer not holding a certificate of authority for that kind of business.

(c) "Obligations," as used in subsection (2)(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 WAC 284-13-515.

(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.

(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 ben-

eficiary, 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 WAC 284-13-515 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) Notwithstanding other provisions of this regulation, when a trust agreement is established in conjunction with a reinsurance agreement covering life, annuities, and disability risks, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may 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:

(A) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies; and

(B) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement.

(ii) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; 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 assuming insurer's share of liabilities, to the extent that the liabilities have not been funded by the assuming insurer, 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 WAC 284-13-515 apart from its general assets, in trust for such uses and purposes specified in (l)(i) and (ii) of this subsection as may remain executory after such withdrawal and for any period after the termination date.

(m) 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.

(n) Notwithstanding any other provision in the trust instrument, if the grantor(s) of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the United States ceding insurers of the grantor(s) of the trust, the assets or any part thereof shall be returned to the trustee for distribution in accordance with 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 pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(II) 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;

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(B) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(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 return of any amount withdrawn in excess of the actual amounts required for (a)(v) of this subsection, and for interest payments at a rate not in excess of the prime rate of interest on the amounts held pursuant to (a)(v) 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) 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 alien insurer in financial statements required to be filed with the insurance commissioner 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, 1996, will continue to be acceptable until December 30, 1997, 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, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-550, filed 2/10/97, effective 3/13/97. 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 WAC 284-13-515. 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) 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 non-renewal.

(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 500, or any successor publication), 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 500, or any successor publication), 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 500, or any successor publication 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 pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies; and

(II) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(B) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified United States financial institution as defined in WAC 284-13-515 apart from its general assets, in trust for such purposes specified in (a)(ii)(A) of this subsection.

tion as may remain after withdrawal and for any period after the termination date.

(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) 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 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.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-560, filed 2/10/97, effective 3/13/97. 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. The credit shall not be greater than the funds held.

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-570, filed 2/10/97, effective 3/13/97. 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. The reinsurance agreement between any ceding insurer claiming credit for reinsurance and an assuming insurer that meets the requirements of this regulation or is in compliance with RCW 48.12.160 and 48.12.162 must include:

(1) A proper insolvency clause pursuant to RCW 48.12.-162 (1)(b); and

(2) A provision stating that an unauthorized assuming insurer:

(a) Has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States;

(b) Has agreed to comply with all requirements necessary to give such court or panel jurisdiction;

(c) Has designated an agent upon whom service of process may be effected; and

(d) Has agreed to abide by the final decision of such court or panel.

[Statutory Authority: RCW 48.02.060, 48.12.154. 05-02-075 (Matter No. R 2004-06), § 284-13-580, filed 1/4/05, effective 2/4/05. 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.]

(2009 Ed.)

WAC 284-13-590 Contracts affected. All new and renewal reinsurance transactions entered into after December 1, 1996, 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, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-590, filed 2/10/97, effective 3/13/97. 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.]

WAC 284-13-595 Form AR-1.

FORM AR-1
CERTIFICATE OF ASSUMING ALIEN INSURER

I, _____,
(name of officer) (title of officer)
of _____,
(name of assuming insurer)
the assuming alien insurer under a reinsurance agreement with one or more insurers domiciled in Washington, hereby certify that _____ ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in the State of Washington for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of the State of Washington as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Commissioner of the State of Washington to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in the State of Washington reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated: _____
(name of assuming insurer)

BY: _____
(name of officer)

(title of officer)

[Statutory Authority: RCW 48.02.060, 48.12.160 and 1996 c 297 § 2. 97-05-012 (Matter No. R 96-10), § 284-13-595, filed 2/10/97, effective 3/13/97.]

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 labelling 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.]

WAC 284-13-850 Scope. (1) The insurance commissioner recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. It is improper, however, for an authorized insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortality or extraordinary survival.

(2) This regulation (WAC 284-13-850 through 284-13-863) applies to all domestic life and disability insurers and to all other licensed life and disability insurers which are not subject to a similar regulation in their domiciliary state. This regulation also applies to the disability insurance policies issued by authorized property and casualty insurers. This regulation does not apply to assumption reinsurance, yearly renewable term reinsurance or nonproportional reinsurance (such as stop loss or catastrophe reinsurance).

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-850, filed 9/8/95, effective 10/9/95.]

WAC 284-13-855 Accounting requirements. (1) No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the commissioner if, by the terms of the reinsurance agreement, in substance or effect, one or more of the following conditions exist:

(a) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Such expenses include commissions, premium taxes and direct expenses including, but not limited to billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

(b) The ceding insurer can be deprived of surplus or assets 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 or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

(c) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement

nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

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

(e) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

(f) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies, for a representative sampling of the products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

Risk categories:

(i) Morbidity.

(ii) Mortality.

(iii) Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(iv) Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

(v) Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or moneys received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(vi) Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

+ - Significant 0 - Insignificant

RISK CATEGORY

	i	ii	iii	iv	v	vi
Disability - other than LTC/LTD*	+	0	+	0	0	0
Disability - LTC/LTD*	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+

(2009 Ed.)

+ - Significant 0 - Insignificant

RISK CATEGORY

Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+

dump-in premiums allowed

*LTC = Long Term Care Insurance

LTD = Long Term Disability Insurance

(g)(i) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in subsection (1)(g)(ii) of this section) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(ii) Notwithstanding (g)(i) of this subsection, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets:

- Disability Insurance - LTC/LTD
- Traditional Non-Par Permanent
- Traditional Par Permanent
- Adjustable Premium Permanent
- Indeterminate Premium Permanent
- Universal Life Fixed Premium
- (no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2(I + CG)}{X + Y - I - CG}$$

- Where:
- I is net investment income (Exhibit 2, Line 16, Column 7)
 - CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6)
 - X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1)
 - Y is the same as X but for the prior year

(ii) Line references are for the commissioner's 1992 annual statement form.

(h) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety days of the settlement date.

(i) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

(j) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

(k) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(2) Notwithstanding subsection (1) of this section, an insurer subject to this regulation may, with the prior approval of the commissioner, take such reserve credit or establish such asset, including actuarial interpretations or standards adopted by the commissioner.

(3)(a) Every agreement entered into after the effective date of this regulation which involves the reinsurance of business issued prior to the effective date of the agreement, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty days after its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the commissioner. The actuary shall maintain adequate documentation and be prepared to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

(b) Any increase in surplus net of federal income tax resulting from arrangements described in (a) of this subsection shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4 of the annual statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "reinsurance ceded" line, page 4 of the annual statement as earnings emerge from the business reinsured.

For example: On the last day of calendar year N, company XYZ pays a \$20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is \$13.2 million (\$20 million - \$6.8 million) which is reported on the "aggregate write-ins for gains and losses in surplus" line in the capital and surplus account. \$6.8 million (34% of \$20 million) is reported as income on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations. At the end of year N+1 the business has earned \$4 million. ABC has paid \$.5 million in profit and risk charges in arrears for the year and has received a \$1 million experience refund. Company ABC's annual statement would report \$1.65 million (66% of (\$4 million - \$1 million - \$.5 million) up to a maximum of \$13.2 million) on the "commissions and expense allowances on reinsurance ceded" line of the summary of operations, and -\$1.65 million on the "aggregate write-ins for gains and losses in surplus" line of the capital and surplus account. The experience refund would be reported separately as a miscellaneous income item in the summary of operations.

[Title 284 WAC—p. 56]

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-855, filed 9/8/95, effective 10/9/95.]

WAC 284-13-860 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 binding letter of intent has been 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.

(3) The reinsurance agreement shall contain provisions which provide that:

(a) The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(b) Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by the parties.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-860, filed 9/8/95, effective 10/9/95.]

WAC 284-13-863 Existing agreements. Insurers subject to this regulation shall reduce to zero by December 31, 1996, any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which under the provisions of this regulation would not be entitled to recognition of the reserve credits or assets; provided however that: The reinsurance agreements are in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

[Statutory Authority: RCW 48.02.060, 48.05.250 and 48.05.400. 95-19-018 (Order 95-4), § 284-13-863, filed 9/8/95, effective 10/9/95.]

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.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-15-100	Surplus lines limited 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.] Repealed by 08-14-169 (Matter No. R 2008-04), filed 7/2/08, effective 8/2/08. Statutory Authority: RCW
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(2009 Ed.)

48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2).

WAC 284-15-010 Brokers—Surplus line—Qualifications and examination. (1) Each applicant for a resident surplus line broker's license must take and pass the required examination and pay the required fee prior to acting as a surplus line broker. The examination will test an applicant's qualifications and competence in all areas of surplus line insurance. Current information about testing procedures and examination dates is available on the commissioner's web site at: www.insurance.wa.gov.

(2) Before the commissioner can issue a surplus line broker's license, the applicant must be licensed in this state as an agent or broker with both property and casualty lines of authority. This requirement may be satisfied if the licenses are issued simultaneously.

(3) The commissioner deems that a nonresident person holding a surplus line broker's license, or the equivalent, in the applicant's home state is qualified, competent and trustworthy and, therefore, meets the minimum standards of this state for holding a surplus line broker's license. For that reason, the commissioner will waive the Washington surplus line broker's examination for a person who has and maintains a current resident surplus line broker's license, or the equivalent, in the applicant's home state.

[Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-010, filed 7/2/08, effective 8/2/08. 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 must 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 and WAC 284-15-090.

(2) A surplus line broker must substantiate the financial condition of an unauthorized insurer before placing insurance with the insurer. The broker must also maintain evidence of the financial condition of the insurer for at least five years.

(a) If a surplus line broker places insurance with an alien unauthorized insurer shown on the National Association of Insurance Commissioners (NAIC) Quarterly Listing of Alien Insurers dated within three months after placement of the risk, it will be deemed that the insurer meets the financial requirements of RCW 48.15.090 and WAC 284-15-090 and that the financial condition of the insurer is adequately documented.

(b) If a surplus line broker places insurance with an alien unauthorized insurer that is not shown on the NAIC Quarterly Listing of Alien Insurers, the broker must maintain information for at least five years adequate to show that the requirements of subsection (1) of this section have been 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, in English with United States dollar equivalents;

(ii) Any other information obtained by the broker that verifies the financial condition of the alien unauthorized insurer; and

(iii) The current NAIC annual statement or its equivalent on file for any alien unauthorized insurer used.

[Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-020, filed 7/2/08, effective 8/2/08. 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: |
|---------------------------|------------------------------------|
- Name and license number of filing Surplus Line Broker:
 - Name and address of producing agent or broker (if any):
 - Name(s) of unauthorized insurer(s):
 - Name and address of insured:
 - Brief statement of coverages (common trade terms may be used, e.g. "furrier's block"):

STATE OF WASHINGTON	}	SS.	SURPLUS LINE
COUNTY			BROKER'S AFFIDAVIT

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

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

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

.....
 (Signature of Surplus Line Broker)
 Subscribed and sworn to before me this day of
, 20...

 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, 06-12-077 (Matter No. R 2006-04), § 284-15-030, filed 6/6/06, effective 7/7/06; 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 to be made upon the 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 an unauthorized insurer elects to designate a person to receive legal process from the commissioner, the designation must be in writing and filed with the commissioner in substantially the form set forth on the commissioner's web site at: www.insurance.wa.gov.

(2) The person designated by the insurer to receive legal process may be an individual, firm or corporation.

(3) The process documents will be forwarded by the commissioner to the person designated in the most recent notice filed with the commissioner.

(4) As specified in RCW 48.15.150, each policy issued by an unauthorized insurer as a surplus line contract must designate the commissioner as the person upon whom service of process may be made.

[Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-040, filed 7/2/08, effective 8/2/08. Statutory Authority: RCW 48.02.060, 06-12-077 (Matter No. R 2006-04), § 284-15-040, filed 6/6/06, effective 7/7/06; 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 and WAC 284-15-090 in circumstances where insurance cannot be otherwise procured on risks located in this state. Except as set forth in subsection (5) of this section, at least the following information must be submitted when a surplus line broker requests the commissioner to waive the financial requirements:

(1) A detailed letter explaining the need to waive the financial requirements;

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

(3) Summary information showing the number of years the company has been writing the specific line of insurance;

(4) A written acknowledgement signed by the proposed insurer confirming all of the following:

(a) The insured has been informed that the coverage will be issued by an insurer (or insurers) that is not an authorized insurer in the state of Washington;

(b) The insured understands that financial requirements for surplus line insurers must be waived by all parties concerned to enable this coverage to be obtained; and

(c) The insured understands that there is no protection for the insured under the Washington Insurance Guaranty Association because the coverage will be issued by an unauthorized insurer;

(5) For accounts requiring a multiplicity of insurers, in lieu of the requirements in subsections (2) and (3) of this section, the commissioner may accept certification from a surplus line broker that the broker has investigated the financial condition of the prospective insurers and is satisfied that they are capable of underwriting the specified risks. Records and documents supporting the broker's certification must be maintained by the broker for the term of the policies and as long thereafter as a claim may be litigated, but in no case less than five years after completion of the transaction.

[Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-050, filed 7/2/08, effective 8/2/08. 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 agent, as permitted by RCW 48.15.080, acceptance of the business does not mean that the agent has become the representative of the insured with respect to that business. In this circumstance:

(1) Return premiums or claim payments will not be deemed to have been paid to the insured or claimant until the payments are actually received by the insured or claimant.

(2) Delivery of notices involving the insurance, such as cancellation or renewal notices, will not be deemed to have been made until actually received by the insured.

[Statutory Authority: RCW 48.02.060, 48.15.040(4), 48.15.073(2), and 48.15.160(2). 08-14-169 (Matter No. R 2008-04), § 284-15-080, filed 7/2/08, effective 8/2/08. 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.]

**Chapter 284-16 WAC
INSURERS**

WAC

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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 subdivided 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.]

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

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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 constitute 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 inap-

appropriate, 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 (2009 Ed.)

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, sub-

ject 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 pro-

spective 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.

(2009 Ed.)

[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

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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.]

(2009 Ed.)

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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MISCELLANEOUS REQUIREMENTS

284-17-600 Licensing requirements for licensees who maintain more than one place of business in the state.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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.

284-17-135 Reexamination after failure to pass. [Statutory Authority: RCW 48.02.060. 88-23-063 (Order R 88-11), § 284-17-135, filed 11/16/88.] Repealed by 98-06-022 (Matter No. R 97-7), filed 2/23/98, effective 3/26/98. Statutory Authority: RCW 48.02.060 and 48.17.130.

284-17-235 Exception to the advanced approval requirement. [Statutory Authority: RCW 48.02.060. 88-01-074 (Order R 87-12), § 284-17-235, filed 12/18/87, effective 3/1/88.] Repealed by 05-07-091 (Matter No. R 2004-04), filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040.

284-17-275 Courses not approved. [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.] Repealed by 05-07-091 (Matter No. R 2004-04), filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040.

284-17-300 Continuing education advisory committee. [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.] Repealed by 98-09-041 (Matter R 98-01), filed 4/14/98, effective 5/15/98. Statutory Authority: RCW 48.02.060, 48.17.150, 48.44.040, 48.46.200 and 48.44.050.

284-17-400 Renewal dates for agents, brokers, solicitors and adjusters. [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.] Repealed by 06-12-025 (Matter No. R 2005-06), filed 5/30/06, effective 6/30/06. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii).

284-17-410 Appointment renewal and termination procedures for insurance agents. [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.] Repealed by 06-12-025 (Matter No. R 2005-06), filed 5/30/06, effective 6/30/06. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii).

284-17-420 Appointment, affiliation and renewal procedures for licensed persons empowered to exercise the authority conferred to a corporate or firm licensee. [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.] Repealed by 06-12-025 (Matter No. R 2005-06), filed 5/30/06, effective 6/30/06. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii).

284-17-451 What information must be provided relating to a "for cause" termination? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-451, filed 5/30/06, effective 6/30/06.] Repealed by 08-17-063 (Matter No. R 2008-03), filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060.

284-17-453 What conduct constitutes "for cause"? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-453, filed 5/30/06, effective 6/30/06.] Repealed by 08-17-063 (Matter No. R 2008-03), filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060.

284-17-459 How long may a licensed agent act as a representative of an insurer and solicit insurance on its behalf before notifying the commissioner of the appointment? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-459, filed 5/30/06, effective 6/30/06.] Repealed by 08-17-063 (Matter No. R 2008-03), filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060.

284-17-461 May a licensed agent act as a representative of an insurer and solicit insurance on its behalf before notifying the commissioner of the appointment if the notice of appointment is not submitted electronically? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-461, filed 5/30/06, effective 6/30/06.] Repealed by 08-17-063 (Matter No. R 2008-03), filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060.

284-17-475 Must an individual licensee who is affiliated with a business entity license be individually appointed by insurers if the business entity is appointed by the insurer? [Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-475, filed 5/30/06, effective 6/30/06.] Repealed by 08-17-063 (Matter No. R 2008-03), filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060.

284-17-570 Implementation dates. [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.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.

EXAMINATIONS

WAC 284-17-120 Examination procedures for agents, solicitors and adjusters. (1) Any person applying to take an examination for any type of license shown in subsection (2) of this section must submit a registration form and the applicable examination fee to an independent testing service under contract with the commissioner for the administration of licensee examinations. This fee is not refundable. Registration forms and information about examinations may be obtained from the office of insurance commissioner, any preclicensing education provider, or from the independent testing service. Current information about the independent testing service, fees, dates of examinations, and other infor-

mation related to licensing examinations, or to download an examination registration form, are available through the commissioner's web site (www.insurance.wa.gov).

(2) At least once 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
Credit casualty agent or solicitor	Credit casualty
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 applicable fees must be submitted for any later examination, unless the fee is waived because the commissioner finds that a serious emergency prevented the applicant's attendance.

(4) Tests will be graded by the independent testing service and each applicant will be provided a score report, following examination. If the examination is passed, the score report must be forwarded by the applicant to the insurance commissioner with a completed insurance license application, one finger print card, appointment form(s) for each insurer to be represented, and the applicable license, finger print, and filing fees.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-120, filed 8/18/08, effective 9/18/08. 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:

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(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 284-17-175 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 What is the purpose of the continuing education regulation? The purpose of WAC 284-17-200 through 284-17-320 is to implement the provisions of RCW 48.17.150. This regulation establishes the minimum continuing education requirements that must be met prior to the renewal of an insurance agent, solicitor or broker license, and specifies minimum criteria that must be met in order to qualify insurance courses for approval.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-200, filed 3/17/05, effective 4/17/05. 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 What definitions are important throughout this chapter? As used in this continuing education regulation, unless the context requires otherwise:

(1) "Approved course" means an educational insurance related program including correspondence courses and seminars that have been approved by OIC.

(2) "Credit hours" means the value assigned to a course by the OIC.

(3) "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. The certificate shall be in standard format, completed in its entirety, and containing such identifying information as is prescribed by the OIC.

(4) "Course number" means the identifying number assigned by OIC for an approved course.

(5) "Course outline" includes summary content and the time allotted by topic.

(6) "Days" means calendar days including Saturday and Sunday.

(7) "Designation course" includes professional studies taken to achieve nationally recognized professional distinctions.

(8) "Instructor" means an individual knowledgeable in topic(s) of discussion.

(9) "Licensee" means an individual licensed under Title 48 RCW, as a resident insurance agent, solicitor or broker to sell life, disability, property, casualty or vehicle insurance. An individual holding a limited license to sell credit life and disability insurance, or travel insurance, or holding a license to sell surety insurance, need not satisfy the continuing education requirement.

(10) "Long-term care (LTC) special education" means education required by individual resident and nonresident agents and brokers prior to transacting long-term care insurance.

(11) "Long-term care (LTC) special education refresher course" means a condensed version of the LTC special education course.

(12) "Monitor" is an individual responsible for verifying class attendance and course content completion.

(13) "Override commission" means compensation received for the sale of insurance by a licensee who is not directly involved with a consumer.

(14) "OIC" means the Washington state office of insurance commissioner.

(15) "Provider" means any insurer, health care service contractor, health maintenance organization, professional association, educational institution created by Washington statutes, or vocational school or independent contractor to which the OIC has granted authority to conduct and certify completion of a course satisfying the insurance education requirements of resident individual agents and brokers.

(16) "Provider number" is the identifying number assigned by OIC to an approved provider of insurance education.

(17) "Refresher LTC special education" means a condensed version of the LTC special education course.

(18) "Reinstatement" means the reissuance of a license that has expired more than sixty days but less than two years from the expiration date of the previous license.

(19) "Request for approval" is a submission of information required for approval of a provider and course.

(20) "Resident" means a licensee who resides in Washington state.

(21) "Roster" is a course attendance record or course purchase and completion record maintained by the provider.

(22) "Schedule" means written notification of when a course will be offered.

(23) "Self-study" means a method of study independent of a classroom setting.

(24) "Surety" insurance includes credit insurance, bail bonds, fidelity, insurance contract performance guarantees, bonds, guarantee undertakings, and contracts of suretyship, and indemnification of banks, bankers, brokers, financial or moneyed corporations or associations against certain losses enumerated in RCW 48.11.080(5).

(25) "Transacting" means 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.

(26) "Vehicle insurance" includes insurance against loss or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therefrom, and against any liability resulting from or incident to ownership.

(27) "Waiver" means an OIC approved exemption from the continuing education requirement.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-210, filed 3/17/05, effective 4/17/05. 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.]

LICENSEES

WAC 284-17-220 Who is required to meet continuing education (CE) requirements? All individual resident agents, brokers and solicitors licensed to sell life, disability, property and casualty lines of insurance must meet the continuing education requirement.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 08-07-102 (Matter No. R 2007-16), § 284-17-220, filed 3/19/08, effective 4/19/08; 06-23-105 (Matter No. R 2006-07), § 284-17-220, filed 11/16/06, effective 12/17/06. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-220, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 48.02.060 and 48.17.150. 98-11-090 (Matter No. R 98-9), § 284-17-220, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.17.150 and 48.85.030. 97-19-007, § 284-17-220, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-17-220, filed 8/13/96, effective 9/13/96. 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 284-17-222 Who is exempt from the continuing education requirements? All individual resident agents licensed under chapter 48.17 RCW to sell credit life and disability, credit casualty, travel, surety lines of insurance, and vehicle insurance are exempt from the continuing education requirement. Resident adjusters are exempt from the continuing education requirement.

[Statutory Authority: RCW 48.02.060 and 48.17.150. 08-07-102 (Matter No. R 2007-16), § 284-17-222, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-222, filed 3/17/05, effective 4/17/05.]

WAC 284-17-224 How many continuing education credits do I need? Currently you are required to complete thirty-two hours of approved continuing education for each license renewal cycle. Effective January 1, 2006, you will be required to complete twenty-four hours of approved continuing education, including three hours of ethics education.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-224, filed 3/17/05, effective 4/17/05.]

WAC 284-17-226 What is required as proof of completion of a course? The course provider will issue you a certificate of completion within fifteen days of completion of the course. For designation courses the passing grade report will be accepted in lieu of a certificate of completion.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-226, filed 3/17/05, effective 4/17/05.]

WAC 284-17-228 What is required for a self-study course? The completion date for a self-study course must be reasonable in relation to the purchase date to allow for adequate time for course completion. For example, if a course is approved for twenty-four hours of continuing education credit, there must be at least three days difference between the course purchase and the completion dates. This information will be verified on the continuing education certificate issued for the course completion. It is assumed that no more than eight course hours can be completed in a single twenty-four hour period.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-228, filed 3/17/05, effective 4/17/05.]

WAC 284-17-230 May I take any approved continuing education course? Yes, the only required subject is three hours of ethics per renewal period.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-230, filed 3/17/05, effective 4/17/05. 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 284-17-232 When must I meet the continuing education requirement? If you are a resident individual licensee with the lines of authority of life, disability, property, casualty or vehicle, you must complete the continuing education requirement as a prerequisite to renewing your license(s). Courses must be completed within the twenty-four months prior to the month of the renewal or reinstatement.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-232, filed 3/17/05, effective 4/17/05.]

WAC 284-17-234 What happens if I am late renewing my license? If your renewal is late, you cannot act under the license until your renewal is processed. Late fees are as follows:

Days late	Surcharge
1 - 30	50% of fee
31 - 60	100% of fee

After sixty days from your expiration date, your license and all associated appointments and affiliations are terminated.

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If your request and fee for license renewal is not received by the expiration date, your authority conferred by the license ends on the expiration date.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-234, filed 3/17/05, effective 4/17/05.]

WAC 284-17-236 What happens if my renewal is received prior to expiration but is incomplete due to the submission of an invalid course(s), an incorrect fee or noncompletion of the renewal notice? If your request and fee for license renewal is not received by the expiration date, your authority conferred by the license ends on the expiration date. If your request and fee for license renewal is received by the expiration date, you may continue to act under your license until the issuance of the renewed license or until the expiration of fifteen calendar days after you were notified that your request for renewal has been refused.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-236, filed 3/17/05, effective 4/17/05.]

WAC 284-17-238 What happens if I do not meet the continuing education requirement? If the continuing education requirement is not met, your license expires and is no longer valid. All appointments and affiliations will be canceled.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-238, filed 3/17/05, effective 4/17/05.]

WAC 284-17-240 Can I reinstate my license? (1) Yes, you may reinstate your license without retesting if no more than two years has passed since your license expired or was canceled. To reinstate you must submit the following:

- (a) An application (INS-14) or your last renewal notice;
 - (b) Continuing education certificates for twenty-four hours of continuing education;
 - (c) Either an appointment or affiliation (INS-18); and
 - (d) The appropriate fee.
- (2) After two years, you will have to take prelicensing education, and a license exam and submit a new application complete with a fingerprint card and the requisite fees.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-240, filed 3/17/05, effective 4/17/05. 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 284-17-242 How long do I have to keep the course completion certificates? You must keep the original certificates for at least three years.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-242, filed 3/17/05, effective 4/17/05.]

WAC 284-17-244 How do I request individual approval for my attendance of an insurance related course that is not already approved? You may attend and request credit for completion of an insurance related course organized and conducted by an entity that is not already approved as a provider. The OIC will make an informed

determination as to the educational value of the course. You must submit the following:

- (1) Proof of attendance by signature of the instructor(s) or person in charge verifying licensee's attendance;
- (2) Sufficient supporting materials regarding course content; and
- (3) Credit hours sought.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-244, filed 3/17/05, effective 4/17/05.]

WAC 284-17-246 Can I get continuing education credit for attending an insurance related college course?

Yes, continuing education credits are granted for college level courses on approved subjects by submitting a transcript showing completion of the course. Hours are determined as follows:

- (1) Twelve hours will be assigned for each college quarter credit hour.
- (2) Sixteen hours will be assigned for each college semester credit hour.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-246, filed 3/17/05, effective 4/17/05.]

WAC 284-17-248 How long are my certificates of completion valid? Certificates of completion are valid for twenty-four months from the course completion date.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-248, filed 3/17/05, effective 4/17/05.]

WAC 284-17-250 Can I repeat a continuing education course? Yes, you can repeat a course with the same course number after three years from the previous completion date.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-250, filed 3/17/05, effective 4/17/05. 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 284-17-252 If I have excess hours (hours that exceed the minimum required for license renewal), can I carry them over to my next license renewal? No, excess hours cannot be carried over to the next license renewal.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-252, filed 3/17/05, effective 4/17/05.]

WAC 284-17-254 How can I be granted a waiver of the continuing education requirements? If you believe good cause exists, you may request a waiver of the continuing education requirement. Requests must be in writing at time of renewal of your license and specify in detail the reason why you believe a waiver is merited.

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(1) Retirement waiver. If your request for a waiver is based upon your retirement, your request must be accompanied by a statement attesting that:

- (a) You are least sixty-five years of age;
- (b) You are retired from selling insurance products; and
- (c) You no longer represent any insurer either directly or through an affiliation with a business entity.

(2) Medical waiver. If your request for a waiver is based upon a medical condition, your request must be accompanied by a physician's statement of your illness or injury.

(3) Military waiver. If your request for a waiver is based upon activation to military service, your request must be accompanied by a copy of the "Letter of Mobilization" and your representative's (the individual given power-of-attorney by the licensee) name and address so that your license renewal notice can be sent to your representative. Your representative must sign the renewal. The renewal and fees must be returned to the OIC. The OIC may waive the continuing education requirement for renewal of your license for the duration of active military service.

A waiver is only valid up to two years from the licensee's regular license renewal date.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-254, filed 3/17/05, effective 4/17/05.]

WAC 284-17-256 If I instruct a class, how many approved credits will I receive? You will receive twice the amount of approved credits if you instruct the entire course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-256, filed 3/17/05, effective 4/17/05.]

LONG-TERM CARE (LTC) SPECIAL EDUCATION

WAC 284-17-258 Long-term care education requirement. (1)(a) Resident and nonresident agents engaged in the transaction of long-term care insurance or long-term care partnership insurance are required to take an approved six-hour course on long-term care or long-term care partnership before soliciting, selling, or otherwise transacting these types of insurance business as to such products with consumers. The four-hour refresher long-term care special education course must be taken every two-year renewal period subsequent to the initial six-hour course. The commissioner prescribes the content of the course. Each course must be approved by the commissioner in advance.

(b) This requirement does not apply to licensees receiving override commissions on long-term care transactions if the licensee has had no contact with the consumer.

(2) This section is effective until December 31, 2008. Long-term care education requirements effective on and after January 1, 2009, are set forth in RCW 48.83.130 and WAC 284-17-264.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-17-258, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-258, filed 3/17/05, effective 4/17/05.]

WAC 284-17-260 Resident and nonresident agents required to complete the long-term care education requirement. (1) Until December 31, 2008, both resident and nonresident agents who transact long-term care business must complete the six-hour long-term care special education course and must complete the four-hour refresher course per renewal period.

(2) The requirements for resident and nonresident long-term care insurance education beginning January 1, 2009, are set forth in RCW 48.83.130 and WAC 284-17-264.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-17-260, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-260, filed 3/17/05, effective 4/17/05. 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 284-17-262 Certification by insurer of completion of long-term care insurance education due date. Beginning January 1, 2009:

(1) Each insurer that has long-term care policies approved for sale in this state must certify annually that all of its insurance producers engaged in the sale, solicitation or negotiation of long-term care insurance coverage in this state have:

(a) Completed the eight-hour, one-time long-term care education and training course required by RCW 48.83.130 (2)(a)(i) prior to selling, soliciting, or negotiating the company's long-term care insurance coverage in this state; or

(b) Completed the required long-term care continuing education requirement imposed by RCW 48.83.130 (2)(b).

(2) The certification must be provided to the commissioner by the insurer annually on or before March 31st. The certification must be sent to the licensing and education program manager in the commissioner's office. A form for this purpose is available on the commissioner's web site: www.insurance.wa.gov.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-17-262, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-262, filed 3/17/05, effective 4/17/05.]

WAC 284-17-264 Reciprocity—Application of long-term care credits to continuing education requirement. Beginning January 1, 2009, all insurance producers are subject to the eight-hour, one-time long-term care training and the four-hour long-term care education requirements of RCW 48.83.130.

(1) Successful completion of approved training in this or any other state by a resident insurance producer, may be used to satisfy the long-term care training requirements of this state.

(2) Resident insurance producers that complete long-term care insurance courses approved in this state to fulfill the required long-term care training may count those course credits toward fulfillment of their Washington continuing education requirement.

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(3) If an insurance producer wishes to apply course credits for the required long-term care training offered in another state and the course is not otherwise approved for continuing education credit in this state, the training may qualify for individual course credit subject to WAC 284-17-244.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-17-264, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-264, filed 3/17/05, effective 4/17/05.]

PROVIDER

WAC 284-17-270 How do I become a provider? To become a continuing education provider, you must meet the standard as required in RCW 48.17.563(1) and complete the provider application (form CEPROVIDER), available on the OIC web site or upon request from the OIC.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-270, filed 3/17/05, effective 4/17/05. 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 284-17-272 What are the responsibilities of an approved provider? An approved provider is responsible for:

(1) Providing the OIC with the name of a contact person who is the responsible person for the provider;

(2) Hiring and supervising instructors who are trustworthy, competent, and knowledgeable;

(3) Providing adequate supervision over instructors;

(4) Notifying, in a format as required by OIC, the OIC with a course schedule at least ten calendar days prior to the course date;

(5) Identifying a monitor, an individual who is responsible for verification of class attendance and course content completion;

(6) Maintaining a roster, consisting of a sign-in/sign-out register for lecture courses;

(7) Maintaining a purchase and completion roster for self-study courses;

(8) Filing the roster in a format as required by OIC, within ten days;

(9) Issuing course completion certificates within fifteen days of completion of course;

(10) Maintaining records for a period of three years from completion date of the course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-272, filed 3/17/05, effective 4/17/05.]

WAC 284-17-274 Is there a fee to become an approved provider or for course approval? No fee is required to become a provider or for the approval of a course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-274, filed 3/17/05, effective 4/17/05.]

WAC 284-17-276 Will I be issued a provider number? Yes. You will be given a provider number that must be included on all certificates of completion.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-276, filed 3/17/05, effective 4/17/05.]

WAC 284-17-278 How do I get a course approved? You must submit a request for approval to the OIC prior to offering the course. This request must include the following:

- (1) Lecture (classroom);
 - (a) Completed course approval request form;
 - (b) Content outline which includes topics and time;
 - (c) Biography or resume of instructor;
 - (d) Date(s) that course is to be offered.
- (2) Self-study;
 - (a) Completed course approval request form;
 - (b) Study material;
 - (c) Sample exams.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-278, filed 3/17/05, effective 4/17/05.]

WAC 284-17-280 What courses are eligible for approval? (1) Courses eligible for approval to satisfy the continuing education requirement are:

- (a) Courses demonstrating a direct and specific application to insurance; and
 - (b) Courses presenting information relevant to insurance related statutory and regulatory requirements.
- (2) General education, sales, motivation, management, leadership, automation, and prelicense training courses are not eligible for approval, unless the provider can demonstrate that a substantial portion of the course relates to the business of insurance and is not solely focused on an individual insurer's product.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-280, filed 3/17/05, effective 4/17/05. 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 284-17-282 Will I be issued a course number? Yes, you will be issued a course number at the time of approval of the course. This number must be included on all certificates of completion for that course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-282, filed 3/17/05, effective 4/17/05.]

WAC 284-17-284 What courses are specifically approved? (Designation courses.)

- (1) The following courses are approved for the maximum number of hours required per renewal period:
 - (a) Any part of the American College Life Underwriting Training Council (LUTC) designation program.
 - (b) Any part of the American College Chartered Life Underwriter (CLU) designation program and advanced study programs.
 - (c) Any part of the Insurance Institute of America's program of insurance.

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(d) Any part of the American Institute for Chartered Property Casualty Underwriter (CPCU) designation program.

(e) Any part of the Certified Insurance Counselor (CIC) program.

(f) Any part of the Health Insurance Association of America (HIAA) designation program.

(g) Any part of the Certified Employee Benefit Specialist (CEBS) designation program.

(h) Any part of the Life Office Management Association (FLMI) designation program.

Changes in the above identified courses are presumed to be approved by the OIC unless the sponsoring organization is advised of disapproval.

(2) The OIC may approve additional designation courses of similar substance.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-284, filed 3/17/05, effective 4/17/05.]

WAC 284-17-286 How are credit hours assigned to a course? The number of credit hours assigned to a course will normally be based upon the number of classroom hours or their equivalent for self-study correspondence courses. However, the number of credit hours assigned may be less than the total amount of time spent by the licensee in the course, based upon an evaluation of the course content. No course will be approved for less than one hour of continuing education credit.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-286, filed 3/17/05, effective 4/17/05.]

WAC 284-17-288 What attendance records must the provider maintain? The provider of a course must maintain an attendance record. This would consist of a sign-in/sign-out register for lecture courses and purchase and completion records for self-study courses.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-288, filed 3/17/05, effective 4/17/05.]

WAC 284-17-290 How long must the provider maintain the attendance or purchase and completion records? The provider must retain such registers, or any other evidence of satisfactory completion, for a period of three years from the date of course completion. The records may be retained in an electronic format.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-290, filed 3/17/05, effective 4/17/05. 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 284-17-292 What must be included on a certificate of completion? The certificate of completion must be in the form specified by OIC and include the following:

- (1) Name of student;

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- (2) Course title and number;
- (3) Date of purchase of course, if applicable;
- (4) Date of completion;
- (5) Number of credit hours;
- (6) Provider name and number;
- (7) Signature of instructor or monitor and date; and
- (8) Certification of completion by student.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-292, filed 3/17/05, effective 4/17/05.]

WAC 284-17-294 Do I have to renew my approval as a provider? No. Your approval as a provider does not need to be renewed as long as you have received approval for a course within the last four years.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-294, filed 3/17/05, effective 4/17/05.]

WAC 284-17-296 Do I have to renew an approval of a course? Yes, a course must be renewed every two years. A renewal notice will be sent by the OIC and must be completed and returned with a copy of the current course material for a correspondence course or outline for a lecture course. If substantial changes have been made in the course curriculum, it should be submitted as a new course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-296, filed 3/17/05, effective 4/17/05.]

WAC 284-17-298 Must I submit an electronic attendance roster? Yes, the provider will be required to submit the attendance roster in a format as determined by OIC.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-298, filed 3/17/05, effective 4/17/05.]

WAC 284-17-301 Does the commissioner have the authority to levy a fine against a CE provider or revoke or suspend a CE provider's approval? After hearing or upon stipulation by the CE provider, and in addition to or in lieu of the suspension, revocation, or refusal to renew any such CE provider approval, the commissioner may levy a fine upon the CE provider.

(1) For each offense the fine shall be an amount not more than one thousand dollars.

(2) The order levying such fine shall specify that the fine must be fully paid not less than fifteen nor more than thirty days from the date of the order.

(3) Upon failure to pay any such fine when due, the commissioner shall revoke the approval of the CE provider, if not already revoked.

The fine may be recovered in a civil action brought on behalf of the commissioner by the attorney general. Any fine so collected will be paid by the commissioner to the state treasurer for the account of the general fund.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-301, filed 3/17/05, effective 4/17/05.]

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WAC 284-17-302 What actions by a provider could result in a fine? The following actions may result in a fine:

(1) Advertising or offering a course without prior approval;

(2) Not following the approved course outline;

(3) Issuing fraudulent completion certificates; and

(4) Recruitment within an advertisement or during the hours of a course presentation.

(5) The provider has failed to comply with or has violated any statute or regulation pertaining to insurance continuing education providers.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-302, filed 3/17/05, effective 4/17/05.]

WAC 284-17-304 Can the approval of a provider be suspended or revoked? (1) Yes, the approval may be suspended or revoked if:

(a) The provider or its employees involved in insurance education have violated any of the provisions of Title 48 RCW or Title 284 WAC; or

(b) The OIC finds under these titles that disciplinary action against any provider is appropriate; the OIC may exercise the discretion to suspend or revoke the provider approval and all of its courses.

(2) Reinstatement of a suspended or revoked approval shall be at the discretion of the OIC after receipt of satisfactory proof that the conditions responsible for the suspension have been corrected.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-304, filed 3/17/05, effective 4/17/05.]

WAC 284-17-306 Can an approval of a course be suspended or revoked? (1) Yes, the approval of a course may be suspended or revoked if the OIC determines that:

(a) The content of an approved course was significantly changed without notice to and approval from, the OIC;

(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; or

(e) The provider failed to comply with the OIC'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 OIC's request.

(2) Reinstatement of a suspended or revoked approval is at the discretion of the OIC. The OIC must receive satisfactory proof that the conditions responsible for the suspension have been corrected.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-306, filed 3/17/05, effective 4/17/05.]

WAC 284-17-308 May I advertise a course prior to approval? No, a course should not be advertised prior to approval.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-308, filed 3/17/05, effective 4/17/05.]

WAC 284-17-310 What must a course advertisement include? A course advertisement must include:

- (1) The provider name;
- (2) The course title;
- (3) A brief description of the course;
- (4) The number of credit hours applied for or approved;
- (5) The location;
- (6) The date and time; and
- (7) The cost of the course.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-310, filed 3/17/05, effective 4/17/05. 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 284-17-312 Does Washington participate in the NAIC Uniform Continuing Education Reciprocity Agreement? (1) Yes, Washington has entered into an agreement with states participating in the NAIC Uniform Continuing Education Reciprocity Agreement. With just a few state specific exceptions, a course approved by a participating state will be accepted by other participating states by submitting NAIC Uniform Continuing Education Reciprocity Course Filing Form and any required attachments.

(2) Participating states have agreed they will not review another state's CE credit hours. Instructor qualifications will also not be reviewed. A standard course filing form will be used for reciprocity filings.

(3) The agreement does not change any of a provider's current duties under Washington law. A provider must still be independently qualified as an approved provider in a participating state.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-312, filed 3/17/05, effective 4/17/05.]

INSTRUCTOR

WAC 284-17-320 What are the qualifications of an instructor? An instructor must be trustworthy, competent and knowledgeable in the subject area being taught.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.17.563, 48.85.040. 05-07-091 (Matter No. R 2004-04), § 284-17-320, filed 3/17/05, effective 4/17/05. 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 284-17-421 Definitions. The following definitions apply to WAC 284-17-421 through 284-17-499, unless the context clearly requires otherwise.

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(1) "Business entity" means a corporation, partnership, firm, limited liability company, or limited liability partnership.

(2) "Sending written notice" or "sending a copy of the written notice" means transmitting the required information in writing and, where required, on forms designated by the commissioner for that purpose, via first class mail, commercial parcel delivery company, telefacsimile, or electronic transmission.

(3) "NIPR" means the National Insurance Producer Registry or other equivalent organization or entity designated or maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-421, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-421, filed 5/30/06, effective 6/30/06.]

WAC 284-17-422 Reciprocity for nonresident agents holding personal lines only authority in the home state. If an otherwise qualified applicant for a nonresident agent's license holds a license in his or her home state limited to personal lines only authority, this state will reciprocate by licensing the nonresident for property and casualty lines of authority.

(1) The licensee's authority to transact insurance in this state is limited to the scope of the license granted by the licensee's home state.

(2) For purposes of this section, "personal lines only authority" means property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-422, filed 8/18/08, effective 9/18/08.]

WAC 284-17-423 How long are initial and reinstated individual licenses in effect? Initial and reinstated individual licenses are valid from the date of issuance until the date of the licensee's next birthday anniversary plus one year.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-423, filed 5/30/06, effective 6/30/06.]

WAC 284-17-425 How long are initial and reinstated business entity licenses in effect? Initial and reinstated business entity licenses are valid for a period of two years from the date of issuance.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-425, filed 5/30/06, effective 6/30/06.]

WAC 284-17-427 What is the renewal period for a license? The renewal period for all licenses is two years.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-427, filed 5/30/06, effective 6/30/06.]

WAC 284-17-429 How long is an initial appointment valid? Initial appointments are valid for the period ending with the insurer's first appointment renewal date after the initial issue date of the appointment. The appointment renewal date for the insurer is assigned by the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-429, filed 5/30/06, effective 6/30/06.]

WAC 284-17-431 What is the renewal period for an appointment? The renewal period for all appointments is two years.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-431, filed 5/30/06, effective 6/30/06.]

WAC 284-17-433 How long is an appointment effective? Each appointment is effective until the agent's license expires or is revoked, the appointment has expired, or written notice of termination of the appointment is received by the commissioner, whichever occurs first.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-433, filed 5/30/06, effective 6/30/06.]

WAC 284-17-435 How will the commissioner notify an insurer that an agent has been appointed? The commissioner will confirm the agent's appointment by sending written notice to the insurer within fifteen calendar days after receipt of the appointment by the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-435, filed 5/30/06, effective 6/30/06.]

WAC 284-17-437 Appointments of agents. An agent may be appointed by using one of the following methods:

(1) By submitting the appointment electronically through NIPR or the commissioner's web site; or

(2) By submitting the appointment to the commissioner using the form provided by the commissioner for that purpose. The form may be found on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-437, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-437, filed 5/30/06, effective 6/30/06.]

WAC 284-17-439 Notice that an agent is not eligible for an electronic appointment. If an agent is not eligible for an electronic appointment, the insurer will be notified at the time the electronic notice of appointment is not accepted for transmission through NIPR or the commissioner's web site. An agent is not eligible for an appointment if the agent's license is not valid or the agent is not licensed for all lines of insurance that the appointing insurer is authorized to transact in the state of Washington.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-439, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-439, filed 5/30/06, effective 6/30/06.]

WAC 284-17-441 Notice to an insurer if an agent is not eligible for an appointment if the appointment was not submitted electronically. If an appointment was not submitted electronically, the commissioner will send a notice to the insurer notifying the insurer that the agent is not eligible for appointment.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-441, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-441, filed 5/30/06, effective 6/30/06.]

WAC 284-17-443 Renewal of an agent's appointment. Prior to the renewal date of an agent's appointment, the

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commissioner will send the insurer an appointment renewal notification. An insurer may renew an appointment by:

(1) Sending notice to the commissioner that the appointment will be renewed on the form provided by the commissioner for that purpose or through the commissioner's web site (www.insurance.wa.gov); and

(2) Paying the renewal fee for each agent appointed by the insurer no later than the renewal date assigned by the commissioner.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-443, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-443, filed 5/30/06, effective 6/30/06.]

WAC 284-17-445 Termination of an appointment by an insurer. (1) An insurer may terminate an appointment by sending written notice of termination to the agent and by sending a notice of termination of the appointment to the commissioner electronically through NIPR, the commissioner's web site, or on the form provided by the commissioner for that purpose. The form may be obtained upon request or may be found on the commissioner's web site (www.insurance.wa.gov).

(2) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-445, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-445, filed 5/30/06, effective 6/30/06.]

WAC 284-17-447 Termination of an appointment by an agent. (1) An agent may terminate an appointment by sending advance written notice to the insurer, with a copy to the commissioner, stating that the agent is no longer authorized to act as a representative of the insurer.

(2) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-447, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-447, filed 5/30/06, effective 6/30/06.]

WAC 284-17-449 Terminating an appointment "for cause." (1) If an insurer terminates the appointment of an agent "for cause," the insurer must notify the insurance commissioner within thirty days following the effective date of the termination by sending notice of the "for cause" termination to the commissioner. A form for this purpose is available on the commissioner's web site (www.insurance.wa.gov).

(2) If requested by the commissioner, the insurer must provide additional information, documents, records or other data pertaining to the "for cause" termination or activity of the agent.

(3) "For cause" includes the following conduct:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any insurance law, or violating any regulation, subpoena or order of the commissioner or of another state's insurance commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any moneys or properties received in the course of transacting the business of insurance;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance license denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Knowingly accepting insurance business from an individual who is not licensed;

(l) Being incompetent;

(m) Failing to account for premiums;

(n) Rebating; and

(o) Abandonment.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-449, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-449, filed 5/30/06, effective 6/30/06.]

WAC 284-17-455 Agent must be licensed for all lines of authority of the appointing insurer. An agent must be licensed for all lines of authority that the appointing insurer is authorized to transact in the state of Washington with the following exceptions:

(1) Insurers authorized to write lines of authority in addition to vehicle insurance or surety insurance may appoint agents to write vehicle insurance or surety insurance only. It is only necessary that these appointees take a qualifying examination for vehicle insurance or surety insurance.

(2) If the agent's appointment is for the "limited" licenses of travel, credit life and disability, credit casualty, specialty producers, or rental car agents, it is not necessary for the applicant to be licensed for all lines of authority that the appointing insurer is authorized to transact in the state of Washington.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-455, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-455, filed 5/30/06, effective 6/30/06.]

WAC 284-17-457 Authority of an agent to act as a representative of an insurer and solicit insurance on its behalf before notifying the commissioner of the appointment. (1) A licensed agent may act as a representative of an insurer and solicit insurance on its behalf before notifying the commissioner of the appointment only if:

(a) The agent is appointed by the insurer; and

(b) The notice of appointment is submitted electronically through NIPR or the commissioner's web site (www.insurance.wa.gov).

(2) This authority is limited to a thirty-day calendar period beginning the date the agent signs the first application for insurance.

(3) If the notice of appointment is not submitted electronically, the commissioner must receive written notice of the appointment and accept the appointment before the licensed agent may act as a representative of an insurer and solicit insurance on its behalf.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-457, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-457, filed 5/30/06, effective 6/30/06.]

WAC 284-17-463 Who is responsible for ensuring that the agent is eligible for appointment? The agent and the appointing insurer are responsible for ensuring that the agent is eligible for appointment.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-463, filed 5/30/06, effective 6/30/06.]

WAC 284-17-467 Consequences—Agent not eligible for appointment by the insurer. If an agent solicits insurance on behalf of an insurer, as authorized by WAC 284-17-457, but it is later determined that the agent was not eligible for appointment by the insurer:

(1) The insurance contract will be effective;

(2) The agent must not receive compensation for any insurance product sold by the agent; and

(3) The agent and the insurer may be subject to disciplinary action under RCW 48.17.530.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-467, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-467, filed 5/30/06, effective 6/30/06.]

WAC 284-17-469 Is the insurer responsible for the acts of the agent during the period of time the agent is acting as a representative of the insurer or soliciting insurance on its behalf? The insurer is responsible for the acts of the agent during the period of time the agent is acting as a representative of the insurer or soliciting insurance on its behalf but before the commissioner is notified of the appointment. This is the case whether or not the thirty-calendar-day period after the date the agent has signed the first application for insurance for submission to the insurer has elapsed. Any misconduct or errors that may occur during this time will be the responsibility of the insurer and the agent.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-469, filed 5/30/06, effective 6/30/06.]

WAC 284-17-471 What are the consequences if the commissioner is not notified of the appointment within thirty calendar days after the date the agent has signed the first application for insurance for submission to the insurer and the agent continues to act as a representative of the insurer or solicit insurance on its behalf? If the commissioner is not notified of the appointment within thirty calendar days after the date the agent has signed the first application for insurance for submission to the insurer, the agent may no longer act as a representative of the insurer or solicit insurance on its behalf. If the agent continues to do so, the insurance will be effective but the agent and the insurer may be subject to disciplinary action under RCW 48.17.530.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-471, filed 5/30/06, effective 6/30/06.]

WAC 284-17-473 "Affiliation," defined—Procedures for affiliation, renewal. "Affiliation" is a type of appointment where a business entity authorizes one or more individual licensed agents, brokers, surplus line brokers or adjusters to represent the business entity. An affiliated licensee may exercise only the authority the business entity confers. The commissioner must receive notice of an affiliation and accept the affiliation before the licensee is allowed to represent the business entity.

(1) Each business entity must submit to the commissioner a notice of affiliation for all licensees authorized to represent the business entity and act on its behalf. A form is provided by the commissioner for that purpose which can be obtained upon request or found on the commissioner's web site (www.insurance.wa.gov).

(2) A licensed business entity must have at least one affiliated individual licensee.

(3) If an agent is affiliated with a licensed business entity, the agent is not required to be directly appointed by an insurer to sell its products if the business entity is appointed by the insurer.

(4) The affiliated agent's, broker's, or surplus line broker's authority to act as a representative of a business entity is limited to those lines of authority for which the agent, broker, or surplus line broker is qualified and that are consistent with the business entity's lines of authority.

(5) If an agent, broker, surplus line broker, or adjuster cannot be affiliated electronically, the commissioner will notify the business entity that the licensee is not eligible for affiliation. A licensee cannot be affiliated under the following circumstances:

(a) The person's license is not valid;

(b) The agent, broker, or surplus line broker is not licensed for at least one of the lines or limited lines of authority that the business entity is authorized to transact in this state; or

(c) The agent is not licensed for at least one of the lines or limited lines of authority of the business entity's appointing insurers.

(6)(a) At the time of renewal of a business entity license, a renewal affiliation list will be sent to the business entity listing the affiliated agents, brokers, surplus line brokers, or adjusters whose affiliations are due to expire.

(b) A business entity may renew an affiliation by sending a list of affiliations to be renewed to the commissioner and paying the renewal fees by mail or through the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-473, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-473, filed 5/30/06, effective 6/30/06.]

WAC 284-17-477 Valid period of an affiliation. A business entity affiliation which is not revoked by the commissioner or is not terminated by the business entity or licensee, is valid until the first renewal date after the notice of affiliation. Each affiliation may be renewed for a period of

two years upon payment of the annual affiliation renewal fee for each affiliation.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-477, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-477, filed 5/30/06, effective 6/30/06.]

WAC 284-17-479 Termination of an affiliation by a business entity. (1) A business entity may terminate the affiliation of an individual licensee by sending notice of termination to the agent and a copy to the commissioner electronically through the commissioner's web site, or by submitting the form provided by the commissioner for that purpose. A form to notify the commissioner of termination of an affiliation by a business entity is available on the commissioner's web site (www.insurance.wa.gov).

(2) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-479, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-479, filed 5/30/06, effective 6/30/06.]

WAC 284-17-481 Requirements for termination of an affiliation by a business entity "for cause." If a business entity or its authorized representative terminates the affiliation of a licensee "for cause," the business entity must notify the commissioner within thirty days following the effective date of the termination by sending notice of termination of the affiliation to the commissioner on the form provided by the commissioner for that purpose, which is available on the commissioner's web site (www.insurance.wa.gov). For purposes of this section, "for cause" has the meaning set forth in WAC 284-17-449(3).

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-481, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-481, filed 5/30/06, effective 6/30/06.]

WAC 284-17-482 Information to be provided relating to a "for cause" termination to the commissioner. Upon the request of the commissioner, the business entity must provide additional information, documents, records or other data pertaining to the "for cause" termination or conduct of the affiliated person. If available in electronic format, the information requested should be provided electronically through the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-482, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-482, filed 5/30/06, effective 6/30/06.]

WAC 284-17-483 Termination of an affiliation by a licensee. (1) An individual agent may terminate an affiliation with a business entity by sending advance written notice to the business entity, with a copy to the commissioner. The notice must state that the agent is no longer authorized to act on behalf of the business entity.

(2) The effective date of the termination is the date of receipt by the commissioner.

[Statutory Authority: RCW 48.02.060. 08-17-063 (Matter No. R 2008-03), § 284-17-483, filed 8/18/08, effective 9/18/08. Statutory Authority: RCW 48.02.060 (3)(a) and 48.17.150 (1)(g)(ii). 06-12-025 (Matter No. R 2005-06), § 284-17-483, filed 5/30/06, effective 6/30/06.]

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 prescribed by WAC 284-17-552 through 284-17-555 for each applicable line.

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

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

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

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

(2) **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.

(2009 Ed.)

[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.

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(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;

(ii) 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 precense 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 precense 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 precense 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 precense 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 precense education plan to be applied throughout Washington state.

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

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

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

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

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

[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:

- (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/rail-road 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;
 - (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.

[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;
 - (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.
- (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 precense 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 copy-rights 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 precense 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 precense 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 precense 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.]

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 284-17A WAC

COMMUNICATIONS EQUIPMENT LICENSES

WAC

284-17A-010	Do I need to be licensed as a specialty producer?
284-17A-020	What definitions are important throughout the chapter?
284-17A-030	How do I apply for specialty producer license?
284-17A-040	How do I renew the license?
284-17A-050	What information must I provide to prospective customers?
284-17A-060	What is included in the written material?
284-17A-070	Do I need to provide training to my employees?
284-17A-080	What are the requirements for the accounting of premiums?
284-17A-090	Does the commissioner have authority to suspend, fine, or revoke my license or refuse to license me?
284-17A-100	What is the effective date of this rule?

WAC 284-17A-010 Do I need to be licensed as a specialty producer? If you lease, sell, or provide communications equipment or communications service, you must have a specialty producer license in order to market insurance related to the sale of the communications equipment.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-010, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-020 What definitions are important throughout the chapter? (1) "Communications equipment" means cell phone handsets, pagers, personal digital assistants, portable computers, automatic answering devices, bat-

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teries, and their accessories or other devices used to originate or receive communications signals or service approved for coverage by rule of the commissioner, and also includes services related to the use of the devices.

(2) "Communications equipment insurance program" means an insurance program.

(3) "Communications service" means the service necessary to send, receive, or originate communications signals.

(4) "Customer" means a person or entity purchasing or leasing communications equipment or communications services from a vendor.

(5) "Specialty producer license" means a license issued that authorizes a vendor to offer or sell insurance.

(6) "Supervising agent" means an agent licensed under RCW 48.17.060 who provides training and is affiliated to a licensed vendor.

(7) "Vendor" means a person or entity resident or with offices in this state in the business of leasing, selling, or providing communications equipment or communications services to customers.

(8) "Appointing insurer" means the insurer appointing the vendor as its agent under a specialty producer license.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-020, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-030 How do I apply for specialty producer license? Forms and instructions may be obtained from the licensing section of the office of insurance commissioner.

To apply for a specialty producer license, you must submit to the licensing section of the OIC the following:

(1) An application with the commissioner signed by the applicant, or an officer of the applicant, and include the following:

- (a) Applicant's name;
- (b) If an entity, the type of entity;
- (c) Address for its primary location in the state of Washington and each additional location at which it intends to offer communications equipment insurance to Washington consumers;
- (d) A copy of its articles of incorporation; and
- (e) A certificate of good standing from the secretary of state.

(2) An appointment as an agent completed by each authorized insurer(s) authorizing the applicant to represent the insurer.

(3) An affiliation completed by the applicant authorizing the supervising agent to represent the applicant. The supervising agent must be licensed under RCW 48.17.060.

(4) Fees:

• License fee	\$500
• Appointment fee	\$20 each
• Affiliation fee	\$20

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-030, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-040 How do I renew the license? A renewal notice will be mailed to each licensed specialty producer in May for renewal by July 1 of each year. You must submit this renewal notice with the two hundred fifty dollar fee, if received prior to the July 1 expiration. If received one

to thirty days late, the fee is three hundred seventy-five dollars. If received thirty-one to sixty days late, the fee is five hundred dollars. If received after sixty days, the license, appointment(s) and affiliation must be reinstated.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-040, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-050 What information must I provide to prospective customers? Approved written material must be readily available to prospective customers at every location where you sell a communications equipment insurance program.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-050, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-060 What is included in the written material? The supervising agent must submit the written materials regarding the program with the initial application for approval with the commissioner. Any changes or additions to this material must be approved by the commissioner prior to implementation. The materials must:

(1) Clearly and correctly summarize the material terms of the coverage offered and identify the insurer and supervising agent or broker;

(2) State that the purchase of the communications equipment insurance program is not required in order to purchase or lease communications equipment;

(3) Separately set forth the charges applicable to the coverage; and

(4) Describe the process for filing a claim.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-060, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-070 Do I need to provide training to my employees? The supervising agent must supervise a communication equipment insurance training program for the vendor's employees. The supervising agent must be authorized and approved by the appointing insurer. The supervising agent must file with the commissioner an outline of the training materials used to train employees of the licensed vendor about the communications equipment insurance program.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-070, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-080 What are the requirements for the accounting of premiums? The specialty producer shall not be required to treat premiums collected from its customers as funds received in a fiduciary capacity, provided that:

The premium charge is separately itemized on customer billings and periodically remitted to the supervising agent pursuant to the terms of a written contract; and

The insurer has consented in writing, signed by an officer of the insurer, that premiums need not be segregated from other funds received by the vendor.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-080, filed 10/23/02, effective 11/23/02.]

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WAC 284-17A-090 Does the commissioner have authority to suspend, fine, or revoke my license or refuse to license me? Yes. The commissioner can deny a license application, fine a vendor, or suspend or revoke a license. See RCW 48.17.540 through 48.17.560. The conduct of your employees and any authorized representatives within the scope of their employment or agency is viewed under the law as your conduct.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-090, filed 10/23/02, effective 11/23/02.]

WAC 284-17A-100 What is the effective date of this rule? Each communications equipment vendor offering communications equipment insurance prior to July 1, 2002, may continue to offer such insurance provided that it makes application for licensure as a communications equipment insurance specialty producer on or before January 1, 2003. The expiration date of this initial license is July 1, 2004.

[Statutory Authority: RCW 48.02.060, 48.120.025. 02-21-119 (Matter No. R 2002-08), § 284-17A-100, filed 10/23/02, effective 11/23/02.]

Chapter 284-17B WAC RENTAL CAR AGENT

WAC

284-17B-005	What definitions are important throughout the chapter?
284-17B-010	Who needs to be licensed as a car rental agent?
284-17B-015	How can I apply for a rental car agent license?
284-17B-020	Do I have continuing reporting and recordkeeping requirements?
284-17B-025	How is a rental car agent license renewed?
284-17B-030	Can the rental car agent endorse someone to act on behalf of the agent?
284-17B-035	Who can be a rental car agent endorsee?
284-17B-040	Is the rental car agent required to provide training and education to its endorseees?
284-17B-045	What activities are prohibited for rental car agents?
284-17B-050	How should a rental car agent account for premiums?
284-17B-055	What information must be included in the rental agreement?
284-17B-060	What information must be included in the written material or brochure?
284-17B-065	What information must be available to prospective renters?
284-17B-070	Should changes to brochures or written materials be submitted to the commissioner?
284-17B-075	Does the commissioner have authority to suspend, fine, or revoke my license or refuse to license me?
284-17B-080	Can the commissioner waive requirements or allow alternative mechanisms for the reporting or training and education requirements?

WAC 284-17B-005 What definitions are important throughout the chapter? Definitions:

(1) **"Endorsee"** means an unlicensed employee or agent of a rental car agent who meets the requirements of this chapter.

(2) **"Person"** means an individual or a business entity.

(3) **"Rental agreement"** means any written master, corporate, group, or individual agreement setting forth the terms and conditions governing the use of a rental car rented or leased by a rental car company.

(4) **"Rental car"** means any motor vehicle that is intended to be rented or leased for a period of thirty consecutive days or less by a driver who is not required to possess a commercial driver's license to operate the motor vehicle and the motor vehicle is either of the following:

(a) A private passenger motor vehicle, including a passenger van, recreational vehicle, minivan, or sports utility vehicle; or

(b) A cargo vehicle, including a cargo van, pickup truck, or truck with a gross vehicle weight of less than twenty-six thousand pounds.

(5) **"Rental car agent"** means any rental car company that is licensed to offer, sell, or solicit rental car insurance under this chapter.

(6) **"Rental car company"** means any person in the business of renting rental cars to the public, including a franchisee.

(7) **"Rental car insurance"** means insurance offered, sold, or solicited in connection with and incidental to the rental of rental cars, whether at the rental office or by preselection of coverage in master, corporate, group, or individual agreements that is:

(a) Nontransferable;

(b) Applicable only to the rental car that is the subject of the rental agreement;

(c) Limited to the following kinds of insurance:

(i) Personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(ii) Liability insurance, including uninsured or underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides protection to the renters and to other authorized drivers of a rental car for liability arising from the operation of the rental car during the rental period;

(iii) Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period; and

(iv) Roadside assistance and emergency sickness protection insurance.

(8) **"Renter"** means any person who obtains the use of a vehicle from a rental car company under the terms of a rental agreement.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-005, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-010 Who needs to be licensed as a car rental agent? Any person in the business of renting cars to the public and offering rental car insurance must either:

(1) Be licensed under chapter 284-17 WAC; or

(2) Comply with chapter 48.115 RCW and this chapter.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-010, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-015 How can I apply for a rental car agent license? Forms and instructions may be obtained by either calling the office of insurance commissioner or downloading them from the web site: www.insurance.wa.gov/. To apply for a rental car agent license, the following must be submitted:

(1) A rental car agent application signed by the applicant, an officer of the applicant, or owner of the rental car-company;

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(2) A copy of articles of incorporation;

(3) A certificate of good standing from the secretary of state;

(4) Underwriting insurer appointment form, INS 18;

(5) The insurer's certification form as described in RCW 48.115.015 (2)(a) signed by the appointing authority;

(6) A list of all locations in Washington identifying the manager or direct supervisor at each;

(7) A list of the names of all endorsees to its rental car agent license;

(8) Certification by the rental car company that the listed endorsees have met the training requirements in RCW 48.115.020(4) and are authorized to offer, sell, and solicit insurance in connection with the rental of vehicles as described in RCW 48.115.005(7).

(9) The training and education program and materials as described in RCW 48.115.020(4) and all brochures and other written materials provided to renters as described in RCW 48.115.025; and

(10) Initial fees:

a. License fee for two years:	\$130 for business with under 50 employees \$375 for business with 50 or more employees
b. Appointment fee:	\$20 for each underwriting insurer
c. Location fee:	\$35 for each additional location. Location fees are not required for locations where there are no endorsees due to waiver or approved alternate arrangement under WAC 284-17B-080

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-015, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-020 Do I have continuing reporting and recordkeeping requirements? (1) Yes. The list of names of all endorsees to the rental car agent license must be updated quarterly on a calendar year basis and submitted at the time of license renewal. The rental car company must retain each list for a period of three years from submission. At any time, endorsee lists must be provided to the commissioner upon request.

(2) The agent must maintain records of each transaction which allows it to identify the endorsee for one year.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-020, filed 10/27/04, effective 11/27/04.]

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-020, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-025 How is a rental car agent license renewed? Rental agent licenses are issued for a period of two years. A renewal notice will be mailed to each licensed rental car agent every other year from the date of issuance. The renewal notice must be submitted with the rental car company certification form and applicable fee:

<i>Date Fees are Received</i>	<i>Fee Every Other Year</i>
	50 OR MORE EMPLOYEES
Prior to or on renewal date:	\$375 with \$35 per each additional location
1-30 days late	\$562.50 with \$35 per each additional location
31-60 days late	\$749.75 with \$35 per each additional location
61 or more days late	New license is required
	UNDER 50 EMPLOYEES
Prior to or on renewal date:	\$130 with \$35 per additional location
1-30 days late	\$195 with \$35 per each additional location
31-60 days late	\$260 with \$35 per each additional location
61 or more days late	New license is required

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-025, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-030 Can the rental car agent endorse someone to act on behalf of the agent? Yes. An endorsee may act on behalf of the rental car agent. The endorsee may act only in the offer, sale, or solicitation of rental car insurance. A rental car agent is responsible for, and must supervise, all actions of its endorsees related to the offering, sale, or solicitation of rental car insurance.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-030, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-035 Who can be a rental car agent endorsee? An employee or agent of a rental car agent may be an endorsee under the authority of the rental car agent license, if all of the following conditions are met:

- (1) The employee or agent is eighteen years of age or older;
- (2) The employee or agent is a trustworthy person and has not committed any act set forth in RCW 48.17.530;
- (3) The employee or agent has completed a training and education program; and
- (4) The employee or agent has a current agreement or business relationship with the rental car company.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-035, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-040 Is the rental car agent required to provide training and education to its endorsees? Yes. The rental car agent must provide training and education to its endorsees as described in RCW 48.115.020(4).

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-040, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-045 What activities are prohibited for rental car agents? A rental car agent must comply with RCW 48.115.030.

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[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-045, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-050 How should a rental car agent account for premiums? A rental car agent is required to treat money collected from renters purchasing rental car insurance as funds received in a fiduciary capacity, unless:

- (1) The charges for rental car insurance coverage are itemized and related to a rental transaction; and
- (2) The insurer has consented in writing that premiums do not need to be segregated from funds received by the rental car agent. This written statement must be signed by an officer of the insurer.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-050, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-055 What information must be included in the rental agreement? The rental agreement must be in writing and include the following:

- (1) Evidence of the rental car insurance coverage stated on the face sheet; and
- (2) An itemized list of all costs.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-055, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-060 What information must be included in the written material or brochure? The brochure and written material must clearly, conspicuously, and in plain language:

- (1) Summarize, clearly and correctly, the material terms, exclusions, limitations, and conditions of coverage offered to renters, including the identity of the insurer;
- (2) Describe the process for filing a claim including a toll-free telephone number to report a claim;
- (3) Provide the rental car agent's name, address, telephone number, and license number, and the commissioner's consumer hotline number;
- (4) Inform the renter that the rental car insurance may duplicate coverage provided by the renter's personal automobile insurance policy, homeowners' insurance policy, or by another source of coverage;
- (5) Inform the renter that when the rental car insurance is not the primary source of coverage, the renter's personal insurance will serve as the primary source of coverage;
- (6) Inform the renter that the purchase of the rental car insurance is not required to rent a car from the rental car agent; and
- (7) Inform the renter that the rental car agent and the endorsees are not qualified to evaluate the adequacy of the renter's existing insurance coverages.

(8) The policy or certificate of coverage and rates must be filed and approved by OIC as outlined in RCW 48.18.100 and 48.19.040.

(9) If the written material includes a certificate of coverage or policy, the form number and edition, if applicable, of the approved certificate of coverage or policy must be identified on the printed material. The insurer must certify that the policy or certificate of coverage and the rates have been

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approved and that the wording on the written material is exactly as approved.

(10)(a) The renter must acknowledge the receipt of the brochures and written materials. The acknowledgment may be in the brochure or written materials, rental agreement, or a separate document.

(b) For transactions conducted by electronic means, the rental car agent must comply with the requirements of (a) of this subsection. Acknowledgment of the receipt of the documents may be made by either written or digital signature.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-060, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-065 What information must be available to prospective renters? Approved written material must be readily available to prospective renters at every location where rental car insurance is offered.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-065, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-070 Should changes to brochures or written materials be submitted to the commissioner? Yes, all changes to brochures and written materials concerning the rental car insurance must be submitted to and approved by the commissioner prior to use. If the brochures have changes unrelated to the rental car insurance, those changes do not have to be submitted and approved.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-070, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-075 Does the commissioner have authority to suspend, fine, or revoke my license or refuse to license me? Yes, the commissioner may fine, suspend, revoke, or refuse to issue a license to a rental car agent or applicant. See RCW 48.115.035.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-075, filed 10/27/04, effective 11/27/04.]

WAC 284-17B-080 Can the commissioner waive requirements or allow alternative mechanisms for the reporting or training and education requirements? Yes. The commissioner may waive or accept alternate arrangements for some or all of the reporting requirements in WAC 284-17B-020 and the endorsee training and education requirements in WAC 284-17B-040 when the endorsees receive no compensation in any form based on the offering or sale of rental car insurance. A request for an alternative arrangement or waiver must be in writing. The request must detail why the reporting or training and education requirement is unduly burdensome due to cost or the nature of the business structure. The request must detail how consumers will be adequately protected under the proposed alternate arrangement or the proposed waiver. A new request must be filed at the time of license renewal.

[Statutory Authority: RCW 48.02.060, 48.30.010, and chapter 48.115 RCW. 04-22-045 (Matter No. R 2002-05), § 284-17B-080, filed 10/27/04, effective 11/27/04.]

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Chapter 284-18 WAC

WASHINGTON INSURANCE HOLDING COMPANY REGULATION

WAC

284-18-300	Forms—General requirements.
284-18-310	Forms—Incorporation by reference, summaries, and omissions.
284-18-320	Forms—Information unknown or unavailable and extension of time to furnish.
284-18-330	Forms—Additional information and exhibits.
284-18-340	Definitions.
284-18-350	Subsidiaries of domestic insurers.
284-18-360	Acquisition of control—Statement filing.
284-18-370	Amendments to Form A.
284-18-380	Acquisition of section 4(1), chapter 462, Laws of 1993, insurers.
284-18-390	Annual registration of insurers—Statement filing.
284-18-400	Summary of registration—Statement filing.
284-18-410	Amendments to Form B.
284-18-420	Alternative and consolidated registrations.
284-18-430	Disclaimers and termination of registration.
284-18-440	Transactions subject to prior notice—Notice filing.
284-18-450	Extraordinary dividends and other distributions.
284-18-460	Adequacy of surplus.
284-18-910	Form A.
284-18-920	Form B.
284-18-930	Form C.
284-18-940	Form D.

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.]

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.]

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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.]

[Title 284 WAC—p. 102]

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

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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 State-
ment 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. corpora-

tion, 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 _____

Attest: _____ (Name) (Title)

(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

FORM C
SUMMARY OF REGISTRATION STATEMENT

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.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate are 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

Date: _____, 19____

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

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, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a nonaffiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

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 other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

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 NONAFFILIATE

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, of 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 284-18A WAC

HEALTH CARE SERVICE CONTRACTOR AND HEALTH MAINTENANCE HOLDING COMPANY REGULATION

WAC

284-18A-300	Forms—General requirements.
284-18A-310	Forms—Incorporation by reference, summaries, and omissions.
284-18A-320	Forms—Information unknown or unavailable and extension of time to furnish.
284-18A-330	Forms—Additional information and exhibits.
284-18A-340	Definitions.
284-18A-350	Acquisition of control—Form A Statement filing.
284-18A-360	Amendments to Form A.
284-18A-370	Annual registration of health carriers—Form B Statement filing.
284-18A-380	Summary of registration—Form C Statement filing.
284-18A-390	Amendments to Form B.
284-18A-400	Alternative and consolidated registrations.
284-18A-410	Disclaimers and termination of registration.

284-18A-420	Transactions subject to prior approval—Form D Notice filing.
284-18A-430	Extraordinary dividends and other distributions.
284-18A-440	Confidential proprietary and trade secret information.
284-18A-910	Form A.
284-18A-920	Form B.
284-18A-930	Form C.
284-18A-940	Form D.
284-18A-950	Form E.
284-18A-960	Dividends and distributions.

WAC 284-18A-300 Forms—General requirements.

(1) Forms A, B, C, D, and E are intended to be guides in the preparation of the statements required by RCW 48.31C.020 through 48.31C.060. They are not intended to be blank forms which are to be filled in. These statements when 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 an answer 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, and E, including exhibits and all other papers and documents filed as a part shall be filed with the commissioner by:

(a) Personal delivery to: Insurance Commissioner of the State of Washington, 5000 Capitol Blvd., Tumwater, WA 98501; or

(b) Mailed to: Insurance Commissioner of the State of Washington, Post Office Box 40259, Olympia, Washington 98504-0259.

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" 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-300, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-310 Forms—Incorporation by reference, summaries, and omissions. (1) Information required by any item of Form A, Form B, Form D, or Form E 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, Form D, or Form E 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.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-310, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-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 obtaining the information 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; 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 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 denies the request within sixty days of receipt.

[Title 284 WAC—p. 110]

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-320, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-330 Forms—Additional information and exhibits. In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, and Form E, 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, D, or E 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-330, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-340 Definitions. (1) "The act" means Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations RCW 48.31C.010 through 48.31C.901.

(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) "Ultimate controlling person" means that person who is not controlled by any other person.

(4) Unless the context otherwise requires, other terms found in these regulations and in RCW 48.31C.010 are used as defined in RCW 48.31C.010. Other terminology is according to Title 48 RCW, or industry usage if not defined by Title 48 RCW.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-340, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-350 Acquisition of control—Form A Statement filing. A person required to file a statement under RCW 48.31C.030, shall provide the required information on Form A, hereby made a part of this regulation.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-350, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-360 Amendments to Form A. The applicant shall promptly advise the commissioner of any changes in the information so furnished on Form A arising after the date upon which the information was provided but prior to the commissioner's disposition of the application.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-360, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-370 Annual registration of health carriers—Form B Statement filing. (1) A health carrier required to file an annual registration statement under RCW

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48.31C.040, shall provide the required information on Form B.

(2) The Form B must be filed within fifteen days after the health carrier becomes subject to registration, and annually on or before May 15th of each year for the previous calendar year.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-370, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-380 Summary of registration—Form C Statement filing. A health carrier required to file an annual registration statement under RCW 48.31C.040 is also required to furnish information required on Form C.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-380, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-390 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-390, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-400 Alternative and consolidated registrations. (1) Any authorized health carrier may file a registration statement on behalf of any affiliated health carrier or health carriers which are required to register under RCW 48.31C.040. A registration statement may include information not required by the act regarding any health carrier in the health carrier holding company system even if the health carrier is not authorized to do business in this state. In lieu of filing a registration statement on Form B, the registered health carrier 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 provided on Form B; and

(b) The filing health carrier is the principal health carrier in the health carrier holding company system.

(2) The question of whether the filing health carrier is the principal health carrier in the health carrier holding company system is a question of fact and a health carrier filing a registration statement or report instead of Form B on behalf of an affiliated health carrier, shall set forth a brief statement of facts which will substantiate the filing health carrier's claim that it, in fact, is the principal health carrier in the health carrier holding company system.

(3) Any health carrier may take advantage of the provisions of RCW 48.31C.040 (7) or (8) without obtaining the prior approval of the commissioner. The commissioner, however, reserves the right to require individual filings if he or

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she deems such filings necessary in the interest of clarity, ease of administration, or the public good.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-400, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-410 Disclaimers and termination of registration. A disclaimer of control or affiliation, or a request for termination of registration shall contain the following information:

(1) The number of authorized, issued, and outstanding voting securities of the health carrier;

(2) 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;

(3) All material relationships and bases for affiliation between the health carrier and the person whose control is denied and all affiliates of such person;

(4) A statement explaining why such person should not be considered to control the health carrier.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-410, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-420 Transactions subject to prior approval—Form D Notice filing. A health carrier required to obtain the prior approval of the commissioner of a proposed transaction pursuant to RCW 48.31C.050, shall provide the required information on Form D, hereby made a part of these regulations.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-420, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-430 Extraordinary dividends and other distributions. (1) Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders or members shall include the following:

(a) The amount of the proposed dividend or distribution;

(b) The date established for payment of the dividend or distribution;

(c) A statement as to whether the dividend or distribution is to be in cash or other property and, if in property, a description, 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 or distribution 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 health carriers own securities) paid within the period of twelve consecutive months ending on the date fixed for payment of the proposed dividend or distribution for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(ii) The net worth of the health carrier as of the 31st day of December next preceding;

(iii) The net income of the health carrier for the twelve-month period ending the 31st day of December next preceding;

(iv) The net worth of the health carrier after payment of the dividend or distribution;

(v) The RBC level of the health carrier after payment of the dividend or distribution;

(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

(2) Each registered health carrier shall report to the commissioner all other dividends and other distributions to shareholders within five business days following the declaration, 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.

(3) The reporting of either dividends or distributions, or both, shall be made under the form in WAC 284-18A-960.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-430, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-440 Confidential proprietary and trade secret information. If the health carrier, applicant or other person filing information with the commissioner under chapter 48.31C RCW and this chapter, considers that some of the information being filed is confidential proprietary and trade secret information, then the person submitting the filing must clearly mark those portions of the filing that the person considers to be confidential proprietary and trade secret information as being confidential. The person making the filing shall also state the basis upon which the person considers the information to be confidential proprietary and trade secret information.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-440, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-910 Form A.

FORM A
STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF A DOMESTIC HEALTH CARRIER

Name of Domestic Health Carrier
BY

Name of Acquiring Person (Applicant)
Filed with the Insurance Commissioner of the State of Washington
Dated: _____
Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

ITEM 1. HEALTH CARRIER AND METHOD OF ACQUISITION

State the name and address of the domestic health carrier 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 health carrier.
- (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 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

Furnish biographical information for (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. Unless otherwise directed by the commissioner, the biographical information shall contain the information required by and be submitted in the format of the current NAIC Biographical Affidavit form.

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 HEALTH CARRIER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such health carrier, 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. NONPROFIT HEALTH CARRIERS

If the health carrier or person controlling the health carrier being acquired is a nonprofit corporation:

(a) Describe who the members of the corporation or person controlling the health carrier are and how they become or are selected as members of the corporation and how this may change as a result of the acquisition.

(b) Describe who has the authority or power to elect or appoint the board of directors, trustees or other governing body of the health carrier or person controlling the health carrier and how this may change as a result of the acquisition.

ITEM 7. FOR-PROFIT HEALTH CARRIERS

If the health carrier being acquired is a for-profit person:

(a) State the number of shares of the health carrier'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 determined.

(b) State the amount of each class of any voting security of the health carrier 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.

(c) Give a full description of any contracts, arrangements or understandings with respect to any voting security of the health carrier 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.

(d) Describe any purchases of any voting securities of the health carrier 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.

(e) Describe any recommendations to purchase any voting security of the health carrier 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.

(f) Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the health carrier for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 8. 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 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. If the applicant is a health carrier or an insurer, 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 statutory accounting principles as set forth in Titles 48 RCW and 284 WAC.

(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 health carrier and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the health carrier, annual reports to the stockholders of the health carrier and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or WAC 284-18A-300 or 284-18A-320.

ITEM 9. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of RCW 48.31C.030 has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the day of _____, _____.

(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 _____, 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, 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-910, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-920 Form B.

FORM B

HEALTH CARRIER HOLDING COMPANY SYSTEM

ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Commissioner of the State of Washington

BY

Name of Registrant

On Behalf of Following Health Carriers.

Name

Address

Dated: _____.

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 health carrier 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 health carrier 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 health carrier holding company system. 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 health carrier 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) If the ultimate controlling person is a for-profit person, 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 the ultimate controlling person is a nonprofit corporation, list the members of the corporation and the board of directors, trustees or other governing body of the corporation.
- (h) 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 biographical information for the executive officers and the directors, trustees or other governing body of the ultimate controlling person. Unless otherwise directed by the commissioner, the biographical information shall contain the information required by and be submitted in the format of the current NAIC Biographical Affidavit form.

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 (no information need be disclosed if such information is not material for purposes of RCW 48.31C.040):

- (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.

The description shall be in a manner as to permit the proper evaluation 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, relationship of the affiliated parties to the registrant, the date of the transaction or agreement and the date the transaction or agreement was approved by the commissioner if such an approval was required.

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 health carrier shall furnish a statement that it has not entered into separate transactions with persons within the health carrier's holding company system which in the aggregate amount exceed the statutory threshold amounts which would have required the commissioner's prior approval or reporting to the commissioner.

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 health carrier 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.

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. If the ultimate controlling person is a health carrier or insurer, the annual financial statements of the ultimate controlling person 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 statutory accounting principles as set forth in Titles 48 RCW and 284 WAC.

(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 284-18A-300 and 284-18A-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 RCW 48.31C.040, 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 _____.

(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 annual registration dated _____, _____, 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, 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-920, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-930 Form C.

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Commissioner of the State of Washington

BY _____

Name of Registrant

On Behalf of Following Health Carriers

Name Address

Date: _____, _____.

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 that permits the proper evaluation 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 health carrier shall furnish a statement that it has not entered into separate transactions with persons within the health carrier's holding company system which in the aggregate amount exceed the statutory threshold amounts which would have required the commissioner's prior approval or reporting to the commissioner.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of RCW 48.31C.040, 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 _____, ____.

(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 summary of registration dated _____, _____, 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, 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-930, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-940 Form D.

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Commissioner of the State of Washington

BY

Name of Registrant

On Behalf of Following Health Carriers

Name

Address

Date: _____, _____.

Name, Title, Address, and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

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 health carrier filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the health carrier seeking approval, or by the health carrier filing the notice in the affiliated parties.

(g) Where the transaction is with a nonaffiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

- (a) A statement of the nature of the transaction.
(b) 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 health car-

rier filing notice, by any party to the transaction, or by any affiliate of the health carrier 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 other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the health carrier 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 health carrier's net worth.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NONAFFILIATE

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 health carrier 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 of, 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 health carrier's net worth.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by RCW 48.31C.050 (2)(c), 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 health carrier 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 health carrier'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 health carrier's net worth.

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 RCW 48.31C.050, the registrant has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the day of _____, _____.

(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 _____, 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, 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, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-940, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-950 Form E.

FORM E

PREACQUISITION NOTIFICATION FORM
REGARDING THE ACQUISITION OF CONTROL OF A FOREIGN HEALTH
CARRIER DOING BUSINESS IN THIS STATE

Name of Applicant

Name of Other Person
Involved in the Acquisition

Filed with the Insurance Commissioner of the State of Washington

Dated: _____.

Name, title, address and telephone number of person completing this statement:

ITEM 1. NAME AND ADDRESS

State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES

State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION

State the nature and purpose of the proposed merger or acquisition.

ITEM 4. NATURE OF BUSINESS

State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.

ITEM 5. MARKET AND MARKET SHARE

State specifically what market and market share the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data.

For purposes of this question, market means direct written premiums in this state for a line of business as contained in the annual statement required to be filed by health carriers licensed to do business in this state.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-950, filed 10/23/02, effective 11/23/02.]

WAC 284-18A-960 Dividends and distributions.

Notification of dividend or distribution to shareholders/members from Washington health carriers

Company Name: _____

NAIC Code: _____

Date Mailed: ___/___/___

- 1A. Amount of dividend or distribution. \$_____
- 1B. How will dividend or distribution be paid* (Circle one). Cash / Property
- 2A. Date dividend or distribution was declared. ___/___/___
- 2B. Date dividend or distribution is to be paid. ___/___/___
- 3A. Dividends paid and distributions made within the previous 12 months from the date on Line 2B:

	Date	How Paid*	Amount
	//	_____	\$ _____
	//	_____	\$ _____
	//	_____	\$ _____
	//	_____	\$ _____
	//	_____	\$ _____
3B.	Total		\$ _____
	*If noncash, describe the property to be distributed and the method used to determine its fair market value.		
4.	Sum of Amounts of Lines 1A and 3B.		\$ _____
5A.	Net Worth as of the previous year-end.		\$ _____
5B.	10% of Amount on Line 5A.		\$ _____
6.	Net Income as of the previous year-end.		\$ _____
7.	The Lesser of Line 5B or Line 6.		\$ _____
8.	Lines 4 minus Line 7.		\$ _____
9A.	If Line 8 is negative, Line 1A is ordinary dividend or distribution.		_____
9B.	If Line 8 is positive, Line 1A is extraordinary dividend or distribution.		_____

If **9A** is checked, notification is required within 5 business days of dividend or distribution declaration and at least 15 business days prior to expected payment or distribution.
 If **9B** is checked, including the above notification requirement, no payment can be made until: The later of (1) 30 days after sufficient notice or if notice is incomplete, then 15 days after receipt of additional information, or (2) 30 days after original receipt; or the commissioner has approved the payment within the 30-day period.

Please note that the payment of any dividend or distribution is prohibited if the payment would reduce the net worth of the health carrier below the greater of: (1) The minimum required by RCW 48.44.037 for a health care service contractor or RCW 48.46.235 for a health maintenance organization or (2) the company action level RBC under RCW 48.43.300 (9)(a).

Certification:

_____ **President/Secretary** _____ **Date**

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, chapter 48.31C RCW. 02-21-123 (Matter No. R 2001-08), § 284-18A-960, filed 10/23/02, effective 11/23/02.]

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

by 87-22-022 (Order R 87-11), filed 10/27/87. Statutory Authority: RCW 48.02.060 and 48.58.010(5).

WAC

284-19-010	Title.
284-19-020	Purposes of program.
284-19-040	Participation.
284-19-050	Definitions.
284-19-060	FAIR plan—Inspections and reports.
284-19-070	FAIR plan business—Distribution and placement.
284-19-080	Procedure after inspection and submission.
284-19-090	Joint reinsurance association.
284-19-100	Standard policy coverage—Coding.
284-19-110	Cancellation and nonrenewal under this program.
284-19-120	Right of appeal.
284-19-130	Commission.
284-19-140	Administration.
284-19-150	Annual and special meetings.
284-19-160	Duties of the committee.
284-19-165	Cooperation of producers.
284-19-170	Public education and notices required.
284-19-180	Statistics, records and reports.

WAC 284-19-010 Title. These rules and regulations are titled the **Washington essential property insurance inspection and placement program** (referred to as the program).

[Statutory Authority: RCW 48.02.060. 98-13-095 (Matter No. R 98-10), § 284-19-010, filed 6/16/98, effective 7/17/98; 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 stated in this chapter.
- (4) To encourage the improvement of the condition of properties located in the state of Washington and to further orderly community development.
- (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 stated in this chapter.

[Statutory Authority: RCW 48.02.060. 06-15-030 (Matter No. R 2006-03), § 284-19-020, filed 7/10/06, effective 8/10/06; 98-13-095 (Matter No. R 98-

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-19-030	Effective date. [Order R-73-2, § 284-19-030, filed 3/30/73; Order R-69-1, § 284-19-030, filed 1/28/69.] Repealed by 98-13-095 (Matter No. R 98-10), filed 6/16/98, effective 7/17/98. Statutory Authority: RCW 48.02.060.
284-19-200	Termination of program. [Statutory Authority: RCW 48.02.060. 86-20-039 (Order R 86-4), § 284-19-200, filed 9/25/86; 84-23-006 (Order R 84-5), § 284-19-200, filed 11/8/84; Order R 77-1, § 284-19-200, filed 3/24/77; Order R-73-2, § 284-19-200, filed 3/30/73; Order R-69-1, § 284-19-200, filed 1/28/69.] Repealed

10), § 284-19-020, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-020, filed 1/28/69.]

WAC 284-19-040 Participation. Participation in this program is 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.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-040, filed 6/16/98, effective 7/17/98; 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 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 or insurance on farm or manufacturing risks.

(3) "Industry placement facility" (referred to as the facility) means the organization formed by insurers to assist applicants 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) "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.

(6) A "service insurer" means any company designated by the facility and approved by the commissioner to issue policies under this program.

(7) "Commissioner" means the commissioner of insurance of the state of Washington.

[Statutory Authority: RCW 48.02.060, 06-15-030 (Matter No. R 2006-03), § 284-19-050, filed 7/10/06, effective 8/10/06; 98-13-095 (Matter No. R 98-10), § 284-19-050, filed 6/16/98, effective 7/17/98; 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 is entitled to an inspection of the property by the inspection bureau at no cost, upon application to the facility. The inspection may be requested by the property owner, a representative of the property owner, the insurer, or the insurance producer and need not be in writing. Requests for inspections shall be trans-

scribed on a form approved by the facility. A deposit premium is not 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 a representative of the applicant, if present, and shall indicate those features which may result in condition charges if the risk is accepted. The inspector has no authority to advise whether the facility will provide the coverage.

(5) The report shall include 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 the applicant's agent upon request.

[Statutory Authority: RCW 48.02.060, 06-15-030 (Matter No. R 2006-03), § 284-19-060, filed 7/10/06, effective 8/10/06; 98-13-095 (Matter No. R 98-10), § 284-19-060, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-060, filed 1/28/69.]

WAC 284-19-070 FAIR plan business—Distribution and placement. (1) The facility shall not require that the applicant demonstrates that he or she is unable to obtain insurance in the normal market, as a precondition to the placement of business under the FAIR plan. The facility, however, may require an agent or broker to furnish copies of documents or information showing what effort was made by the agent or broker to obtain insurance in the normal market. The facility shall forward to the commissioner the names of 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) Assessments upon each insurer participating in this program shall be levied by the facility on the same percentage allocation basis as the 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 that may be placed through this program on any one property at one location is \$1,500,000. The facility undertakes the responsibility of seeking to place that portion of a risk that exceeds \$1,500,000.

(b) The term "at one location" as used in this chapter 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 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-070, filed 6/16/98, effective 7/17/98. 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) Within three business days after receipt of

the inspection report, the facility shall notify the insured and the agent 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 facility, and upon receipt of premium, the policy or binder shall be delivered within two business days. No coverage shall commence until the application is accepted and the premium paid to the facility.

(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 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 is not an acceptable criterion for declining a risk.

(4) If 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 will have the property promptly reinspected.

(5) If the inspection of the property reveals that there are one or more substandard conditions, surcharges shall 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, the applicant may make to bring the property to insurable condition at unsurcharged rates.

[Statutory Authority: RCW 48.02.060. 98-13-095 (Matter No. R 98-10), § 284-19-080, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-080, filed 1/28/69.]

WAC 284-19-090 Joint reinsurance association. (1) A joint reinsurance association referred to as the association is created consisting of all insurers.

(2) The association is authorized to assume and cede reinsurance on behalf of insurers for eligible risks written by insurers through the FAIR plan. The reinsurance assumed by the association is 100% of each risk written under this program under \$1,500,000.

(3) Each insurer participates in the total writings, expenses, profits and losses of the association in proportion to its premiums written.

(4) If 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, the unpaid loss or expense shall be paid by the remain-

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ing members. Each remaining member contributes in the manner provided for in the distribution of expenses and losses under the program, deleting the proportion of the defaulting member. The facility is subrogated to the rights of the remaining members in any liquidation proceeding and has full authority on their behalf to exercise such rights in any action or proceeding.

[Statutory Authority: RCW 48.02.060. 98-13-095 (Matter No. R 98-10), § 284-19-090, filed 6/16/98, effective 7/17/98; 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. The policies shall be separately coded and issued for a term of one year, at rates set by the inspection bureau under filings approved by the commissioner. Individual company deviation filings shall not apply to risks written under this program.

[Statutory Authority: RCW 48.02.060. 98-13-095 (Matter No. R 98-10), § 284-19-100, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-100, filed 1/28/69.]

WAC 284-19-110 Cancellation and nonrenewal under this program. (1) The facility shall not cancel or nonrenew a policy issued under this program except:

(a) For cause which would have been grounds for nonacceptance of the risk under the program had the 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 or nonrenewal, together with a statement of the reason, shall be sent to the insured.

(3) Any cancellation or nonrenewal notice to the insured shall be accompanied by a statement that the insured has a right of appeal as provided in WAC 284-19-120.

[Statutory Authority: RCW 48.02.060. 98-13-095 (Matter No. R 98-10), § 284-19-110, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-110, filed 1/28/69.]

WAC 284-19-120 Right of appeal. (1) Any applicant or insurer has 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.

(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) The committee shall make decisions in writing on appeals within fifteen business days after notification of appeal is received, unless delayed by mutual consent. The majority of committee members must concur in all decisions adverse to the party seeking appeal.

(7) Appeals to the commissioner under this program, in all other respects not set forth in this chapter, shall be handled

in accordance with chapters 48.04 and 34.05 RCW (Administrative Procedure Act).

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-120, filed 6/16/98, effective 7/17/98; 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 paid to the licensed producer designated by the applicant.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-130, filed 6/16/98, effective 7/17/98; 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 (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) The committee consists of nine members, including five insurers, one of which is elected from each of the following:

- (a) American Insurance Association;
- (b) Alliance of American Insurers;
- (c) National Association of Independent Insurers;
- (d) All other stock insurers; and
- (e) All other nonstock insurers.

A sixth member shall be an insurer designated as the service insurer under the program. The commissioner shall designate a sixth member if there is more than one service insurer. The other three members are individuals who are appointed by the commissioner to serve, none of whom have a direct or indirect interest in any insurer except as a policyholder. The individual members 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 may issue operating procedures and other directives to carry out the purposes of this plan and directives of the commissioner.

(4) Each person serving on the committee or any subcommittee, 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 in connection with the defense of any action, suit, or proceeding in which he or she is made a party by reason of 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 she has been judged in such action, suit, or proceeding to be liable by reason of willful misconduct in the performance of duties as a member of the committee, or a member or officer or employee of the facility. This indemnification does not apply to any loss, cost, or expense on insurance policy claims under the program. Indemnification is not exclusive of other rights to which such member or officer may be entitled as a matter of law.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-140, filed 6/16/98, effective 7/17/98. 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.]

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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 associations (WAC 284-19-140(2)) 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 a 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 the annual or special meeting shall be given in writing by the committee to the insurers. A majority of the insurers constitutes a quorum. Voting by proxy is permitted. Notice of any meeting shall be accompanied by an agenda for the meeting.

(4) Any matter, including amendment of this program, may be proposed and voted upon by mail, provided the procedure is unanimously authorized by the members of the committee present and voting at any meeting of the committee. If approved by the committee, notice of any proposal is mailed to the insurers not less than twenty days prior to the final date fixed by the committee for voting.

(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 becomes effective when approved by at least two-thirds of the votes cast on the weighted basis, except amendments to this program that will require administrative action by the commissioner.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-150, filed 6/16/98, effective 7/17/98; 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 may appoint a manager to budget expenses, levy assessments, disburse funds and perform all other duties provided in this chapter or necessary or incidental to the proper administration of the program. The manager serves at the pleasure of the committee. The adoption of or substantive changes in pension plans or employee benefit programs is subject to approval of the insurers. Assessments upon each insurer shall be levied on the basis of its premiums written.

(3) Annually the manager prepares an operating budget that is subject to approval of the committee. The budget shall be furnished to the insurers after approval. Any contemplated expenditure in excess of or not included in the annual budget requires prior approval by the committee.

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(4) The committee furnishes to all insurers and to the commissioner a written report of operations annually in a form and detail as the committee may determine.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-160, filed 6/16/98, effective 7/17/98; 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 program receives adequate public attention.

(2) All insurers terminating a property insurance policy shall give any policyholder eligible for coverage under this program notice of cancellation or refusal to renew as required under chapters 48.18 and 48.53 RCW. The insurers shall explain the procedure for making application under this program in or accompanying the notice.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-170, filed 6/16/98, effective 7/17/98; 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. The facility shall make:

- (a) A quarterly report to the commissioner including:
 - (i) Number of requests for inspections,
 - (ii) Number of risks inspected,
 - (iii) The number of risks accepted, total and average premiums charged, high and low premiums,
 - (iv) The number of risks declined, and
 - (v) The number of reinspections made on conditionally declined risks.

(b) Additional reports as required by the commissioner.

(2) **Records.** 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. The reports shall include:

- (a) Premiums written and earned;
- (b) Losses, including loss adjustment expense, paid and incurred;
- (c) All other expenses incurred; and
- (d) Outstanding liabilities.

[Statutory Authority: RCW 48.02.060, 98-13-095 (Matter No. R 98-10), § 284-19-180, filed 6/16/98, effective 7/17/98; Order R-69-1, § 284-19-180, filed 1/28/69.]

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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.
284-20-200	Retention of policy forms.

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.
284-20-070	Catastrophe coverage. Repealed by 98-22-109 (Matter No. R 98-13), filed 11/4/98, effective 12/5/98. Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170.
284-20-100	Modification of form filing requirements. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170, 98-22-109 (Matter No. R 98-13), § 284-20-100, filed 11/4/98, effective 12/5/98. Statutory Authority: RCW 48.02.060 (3)(e), 86-24-043 (Order R 86-7), § 284-20-100, filed 11/26/86.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-20-150	Rules that exempt certain commercial property casualty forms from filing requirements. [Statutory Authority: RCW 48.02.060, 48.18.100(6), and 48.18.103(3), 06-07-098 (Matter No. R 2005-03), § 284-20-150, filed 3/15/06, effective 4/15/06.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.

WAC 284-20-006 Washington Insurance Examining Bureau, Inc.—Audits to test adherence to rate filings. (1) In performing the duty of determining 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. The commissioner finds, however, as to all kinds of insurance falling within the scope of chapter 48.19 RCW, that occasions may arise where documents with respect to certain policies should be submitted for examination in order to determine that lawful rates are being charged.

The required submission should be on a random audit basis or by designation of certain specific policies.

(2) Based on the preceding subsection and under RCW 48.19.410 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, the following information that relates to property insurance as defined in RCW 48.11.040:

- (i) Any policies and the related daily reports;
 - (ii) Binders;
 - (iii) Renewal certificates;
 - (iv) Endorsements; and
 - (v) Other evidences of insurance or the cancellation of insurance.
- (b) Shall make available to the bureau, the information listed in (a)(i) through (v) of this subsection:

(i) When directed to do so by the commissioner regarding a specifically identified policy; and

(ii) 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, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-006, filed 11/4/98, effective 12/5/98. 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 multiperil 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. Every basic contract of fire insurance shall provide only 12:01 a.m. standard time as the time of inception and expiration. The 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."

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-020, filed 11/4/98, effective 12/5/98; 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 that may be classified under the insurance code as marine, inland marine or transportation insurance. This regulation does not include all of the kinds of risks and coverages that may be written, classified or identified under marine, inland marine or transportation insuring powers, nor shall it mean that the kinds of risks and coverages are solely marine, inland marine or transportation insurance in all instances.

(2) This regulation does not restrict or limit in any way the exercise of any insuring powers granted under charters and license.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-030, filed 11/4/98, effective 12/5/98; 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, is 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 is deemed to have been completed when the 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, is 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 the 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 semitrailers 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. The 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. The 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. The policies may include coverage of furniture, fixtures and tenant insured's interest in the improvements and betterments of buildings as are located in that portion of the premises occupied by the insured in the practice of his or her 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 the 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. The 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) The coverage is 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. The 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.) The 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. The 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) The merchandise is specifically identifiable as encumbered to the bank or lending institution.

(ii) The dealer's right to sell or otherwise dispose of the merchandise is conditioned upon its being released from encumbrance by the bank or lending institution.

(iii) The policies cover in transit and do not extend beyond the termination of the dealer's interest.

The 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.

The policies may include coverage of money in locked safes or vaults on the insured's premises. The 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.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-040, filed 11/4/98, effective 12/5/98; 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, WAC 284-20-030 and 284-20-040 do not permit marine or transportation policies to cover:

(1) Storage of insured's merchandise, except as provided in this chapter.

(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) Moneys and/or securities in safes, vaults, safety deposit vaults, bank or insured's premises, except while in course of transportation.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-050, filed 11/4/98, effective 12/5/98; Order R 77-3, § 284-20-050, filed 5/20/77; Rule made 1/31/56, filed 3/22/60.]

WAC 284-20-200 Retention of policy forms. Beginning July 1, 1996, every insurer shall adopt a record retention procedure and shall maintain records sufficient to reconstruct a copy of every general liability insurance policy issued for delivery in this state to a Washington resident on or after July 1, 1996.

(1) Records may be kept in any reasonable and customary format, including any photographic or electronic format.

(2) Records shall be kept for at least twenty years following the expiration date of the policy.

(3) The insurer shall maintain the capacity to retrieve records sufficient to reconstruct any policy by name of the named insured(s) as shown on the policy declarations page and by policy number.

(4)(a) The insurer shall keep either a copy of each form of general liability insurance policy issued to a resident of this state so that it can be matched to an insured's record upon request, or a copy of the insured's policy as issued. For manuscript policies, the insurer shall retain a copy of the insured's policy as issued.

(b) For each insured, the insurer shall maintain at least the following information as the insured's record:

(i) The name of all named insureds as shown on the policy declarations page;

(ii) The address of the named insured as shown on the policy declarations page;

(iii) The name of any additional named insured(s);

(iv) The policy number;

(v) The form number(s) or a copy of the insured's policy as issued;

(vi) The limits of liability;

(vii) The annual premium;

(viii) The form number(s) or a copy of any endorsement(s); and

(ix) The policy period.

(5) Records of general liability insurance policies issued to Washington residents and that are in the possession of the insurer on the effective date of this section shall not be destroyed for twenty years after the effective date of this section. The records do not need to be catalogued or indexed to meet the standards of this section.

(6) Records of general liability insurance policies issued by unauthorized insurers shall be kept in this state; however, the records may be maintained on behalf of an unauthorized insurer by the surplus line broker of record on the policy, or the broker's successor.

(7) For purposes of this section, "general liability insurance policy" means a contract of insurance that provides coverage for the legal obligations of an insured for bodily injury or property damage to others. It includes, for example, pollution liability insurance policies and comprehensive general liability insurance policies; it does not include insurance policies relating to motor vehicles, personal coverage such as homeowners, or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance, or other similar policies.

(2009 Ed.)

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 98-22-109 (Matter No. R 98-13), § 284-20-200, filed 11/4/98, effective 12/5/98; 95-09-014 (Order R 94-30), § 284-20-200, filed 4/10/95, effective 5/11/95.]

Chapter 284-20A WAC

RULES THAT APPLY TO INSURERS THAT UNDERWRITE MEDICAL MALPRACTICE INSURANCE

WAC

284-20A-010	Purpose.
284-20A-020	Definitions that apply to RCW 48.18.290, 48.18.2901, 48.18.547 and this chapter.
284-20A-030	Information a medical malpractice insurer must provide to the insured if the insurer takes an adverse underwriting action.
284-20A-040	Use of "substantive underwriting factors" when underwriting new or existing medical malpractice insurance policies.
284-20A-050	What constitutes a medical malpractice insurance policy for the purposes of RCW 48.18.290 (1)(b) and 48.18.2901 (1)(a)(ii)?

WAC 284-20A-010 Purpose. This chapter describes the underwriting restrictions that apply to medical malpractice insurers under RCW 48.18.290, 48.18.2901 and 48.18.547.

[Statutory Authority: RCW 48.02.060 and 48.18.547. 06-17-054 (Matter No. R 2006-01), § 284-20A-010, filed 8/10/06, effective 9/10/06.]

WAC 284-20A-020 Definitions that apply to RCW 48.18.290, 48.18.2901, 48.18.547 and this chapter. The definitions in RCW 48.18.547(1) apply to this chapter. In addition, the definitions in this section apply throughout the chapter:

(1) **"Medical malpractice"** has the same meaning as in RCW 48.140.010(9).

(2) **"Provider"** includes both a facility and provider as defined in RCW 48.140.010 (6) and (7).

(3) **"Risk profile"** means characteristics of a provider that increase or decrease the potential for future medical malpractice claims that may fall in the scope of coverage of a medical malpractice insurance policy.

[Statutory Authority: RCW 48.02.060 and 48.18.547. 06-17-054 (Matter No. R 2006-01), § 284-20A-020, filed 8/10/06, effective 9/10/06.]

WAC 284-20A-030 Information a medical malpractice insurer must provide to the insured if the insurer takes an adverse underwriting action. Significant risk factors are the components of a risk profile that require notice under RCW 48.18.547(3). If a provider has any significant risk factors that affect the provider's risk profile and may increase the potential for future medical malpractice claims, the insurer must explain each significant risk factor to the insured in clear and simple language.

(1) The insurer must explain to the insured how each significant risk factor adversely affects the insured's:

(a) Eligibility for insurance;

(b) Eligibility for premium credits; or

(c) Ability to buy insurance without the application of rating rules that result in premium debits, surcharges, or assessments.

(2) Insurers do not have to provide notice if:

(a) The provider asks for product options that increase premium or reduce coverage, such as:

- (i) Deductible or retention changes;
- (ii) Increased coverage limits; or
- (iii) Coverage options.

(b) The provider changes their business in a way that increases exposure, such as adding staff or types of services performed; or

(c) The classification plan includes rating rules that result in automatic premium increases, such as a claims-made policy step-rating rule that increases premium based on years of practice.

(3) For the purposes of this section:

(a) **"Classification plan"** means a plan to formulate different premiums for the same coverage based on group characteristics. Classification plans group, for rating purposes, risks that have similar insuring, risk and exposure factors.

(b) **"Premium"** has the same meaning as in RCW 48.18.170.

(c) **"Rating rule"** means a factor, formula, rule or procedure used to calculate premium. Rating rules include, but are not limited to:

- (i) Experience rating plans;
- (ii) Rating factors or tiers;
- (iii) Surcharge or discount rules; and
- (iv) Schedule rating plans.

(d) **"Significant risk factor"** means a material element of the insured's risk profile that contributes to or results in an adverse underwriting action by a medical malpractice insurer. Substantive underwriting factors, as defined in WAC 284-20A-040 (3)(a) are presumed to be significant risk factors.

[Statutory Authority: RCW 48.02.060 and 48.18.547. 06-17-054 (Matter No. R 2006-01), § 284-20A-030, filed 8/10/06, effective 9/10/06.]

WAC 284-20A-040 Use of "substantive underwriting factors" when underwriting new or existing medical malpractice insurance policies. (1) The definition of "underwriting" in RCW 48.18.547 (1)(e) is broad, and includes selecting, rejecting and pricing a risk. Underwriting occurs when a provider first applies for insurance and when the insurer evaluates the provider for renewal purposes.

(2) Insurers are prohibited from considering the factors listed in RCW 48.18.547(2) during any underwriting process unless the insurer can demonstrate that other substantive underwriting factors were also considered. Upon request by the commissioner, an insurer must demonstrate that a completed underwriting process complies with RCW 48.18.547 (2). Insurers must retain documentation of each underwriting process for three years.

(3) For the purposes of this section:

(a) **"Substantive underwriting factor"** means a factor that is very important to an underwriting decision. An insurer may use other substantive underwriting factors in an underwriting process if they are comparable in importance to the factors listed in this definition. Examples of substantive underwriting factors include, but are not limited to:

- (i) Criminal acts, including sexual misconduct;
- (ii) Changes in financial condition;

(ii) Changes in operations that have a reasonable relationship to underwriting, such as changes in:

- (A) Management or professional staff;
- (B) Location of business;
- (C) Business relationships;
- (D) Medical specialty; or
- (E) Medical procedures performed;

(iv) Failure to comply with loss control or loss prevention recommendations within a reasonable period;

(v) Failure to provide information necessary to underwrite the policy;

(vi) History of claims, if the insurer can demonstrate they adversely affect the insured's risk profile;

(vii) Investigations, disciplinary action, restrictions or limitations imposed by or related to a state or federal licensing or administrative agency, law enforcement agency, attorney general, or similar agency or official;

(viii) Performing procedures outside the scope of an individual's license and/or training;

(ix) Substance abuse;

(x) Inadequate facilities, equipment, or maintenance of facilities or equipment;

(xi) Inadequate staff training program;

(xii) Peer review or credentialing actions, or changes in staff privileges, such as suspension, restriction, revocation, surrendered privileges, or other termination; or

(xiii) Unprofessional conduct, as defined in RCW 18.130.180.

(b) **"Underwriting process"** means any series of actions that produce an underwriting decision that affects a provider.

[Statutory Authority: RCW 48.02.060 and 48.18.547. 06-17-054 (Matter No. R 2006-01), § 284-20A-040, filed 8/10/06, effective 9/10/06.]

WAC 284-20A-050 What constitutes a medical malpractice insurance policy for the purposes of RCW 48.18.-290 (1)(b) and 48.18.2901 (1)(a)(ii)? A medical malpractice insurance policy means an insurance policy written with the principal intent to provide medical malpractice insurance. For the purposes of this section, a policy does not include medical malpractice insurance written as ancillary coverage to a general liability or package policy if the principal exposure insured is not medical malpractice.

[Statutory Authority: RCW 48.02.060 and 48.18.547. 06-24-039 (Matter No. R 2006-08), § 284-20A-050, filed 11/30/06, effective 12/31/06; 06-17-054 (Matter No. R 2006-01), § 284-20A-050, filed 8/10/06, effective 9/10/06.]

Chapter 284-20B WAC

RULES FOR FILING PROPERTY AND CASUALTY FORMS

WAC

284-20B-005
284-20B-010
284-20B-020

Definitions that apply to this chapter.
Purpose and scope of this chapter.
Filing instructions that are incorporated into this chapter.

284-20B-030
284-20B-040
284-20B-050
284-20B-060
284-20B-070
284-20B-080

General form filings rules.
The commissioner may reject filings.
Rules for rejected filings made under RCW 48.18.103.
Filing authorization rules.
Rating organization "bureau" rules.
Use of rating organization "bureau" forms—No filing authorization.

284-20B-090	Advisory organization rules.
284-20B-100	Rules for responding to an objection letter.
284-20B-110	Applications and policyholder notices.
284-20B-120	Rules for revised or replaced insurance policy forms.
284-20B-130	Effective date rules.
284-20B-140	Reference copies of amendatory endorsements.
284-20B-150	Rules for insurance policy forms translated from English to another language.
284-20B-160	Exemption for unauthorized insurers.
284-20B-170	Exemption for insurance forms issued to large commercial property and casualty accounts.

WAC 284-20B-005 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter:

(1) "Advisory organization" means an entity not licensed under RCW 48.19.180 that files advisory forms with the commissioner.

(2) "Complete filing" means a package of information containing insurance forms, supporting information, documents and exhibits submitted to the commissioner electronically using the System for Electronic Rate and Form Filing (SERFF).

(3) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(4) "Filer" means a person, organization or other entity that files insurance forms with the commissioner for an insurer.

(5) "Insurance" means the same as in RCW 48.01.040.

(6) "Insurer" means an insurer defined in RCW 48.01.-050 to which the commissioner has issued a certificate of authority under chapter 48.05 RCW.

(7) "Member" or "subscriber" means an insurer that has granted filing authority to a rating organization under RCW 48.19.050, and includes service purchasers.

(8) "NAIC" means the National Association of Insurance Commissioners.

(9) "Objection letter" means correspondence created in SERFF and sent by the commissioner that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a form under RCW 48.18.110.

(10) "Property and casualty insurance" means all types of:

(a) Property insurance defined in RCW 48.11.040;

(b) Marine and transportation insurance defined in RCW 48.11.050;

(c) Vehicle insurance defined in RCW 48.11.060;

(d) General casualty insurance defined in RCW 48.11.070; and

(e) Title insurance defined in RCW 48.11.100.

(11) "Rating organization" or "bureau" means an entity licensed under RCW 48.19.180 that files forms on behalf of its members, subscribers, and service purchasers.

(12) "SERFF" means the System for Electronic Rate and Form Filing. SERFF is a proprietary NAIC computer-based application that allows filers to create and submit rate, rule and form filings electronically to the commissioner.

(13) "Type of insurance" means a specific type of insurance listed in the *Uniform Property and Casualty Product Coding Matrix* published by the NAIC and available at www.naic.org.

(2009 Ed.)

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-005, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-010 Purpose and scope of this chapter. (1) The purpose of this chapter is to adopt processes and procedures for insurers and filers to use when they submit property and casualty insurance forms to the commissioner under chapter 48.18 RCW.

(2) This chapter applies to insurers, advisory organizations and rating organizations that file property and casualty insurance forms under RCW 48.18.100 and 48.18.103.

(3) This chapter is effective on February 1, 2009. All form filings received on or after February 1, 2009, must comply with this chapter.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-010, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-020 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner must incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* posted on the SERFF web site (www.serff.com); and

(2) The *Washington State SERFF Property and Casualty Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-020, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-030 General form filings rules. Filers must submit complete filings that comply with the *SERFF Industry Manual* posted on the SERFF web site (www.serff.com) and *Washington State SERFF Property and Casualty Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov). All form filings must comply with these rules:

(1) Insurers must file property and casualty insurance forms under RCW 48.18.100(1) or 48.18.103(3). Filers may not use the certification process described in RCW 48.18.100 (2) to file property and casualty insurance forms.

(2) Filers must submit all insurance forms and related documents to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must be attached to the form schedule.

(b) All written correspondence related to a form filing must be sent in SERFF.

(3) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new and replacement forms to the commissioner for review in final form displayed in ten-point or larger type.

(4) Each form must have a unique identifying number and a way to distinguish it from other editions of the same form.

(5) Filers must not submit combined rate and form filings.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-030, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-040 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-20B-030. If the commissioner rejects a filing, the insurer has not filed forms with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-040, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-050 Rules for rejected filings made under RCW 48.18.103. RCW 48.18.103(3) says an insurer must file forms within thirty days after the insurer issues them. If the commissioner rejects a filing under WAC 284-20B-040, the insurer has not filed forms with the commissioner. If the commissioner rejects a filing submitted under RCW 48.18.103, the:

(1) Filer must promptly send a new filing to the commissioner within the original thirty-day use and file period in RCW 48.18.103(3); or

(2) Insurer must stop issuing policies using forms sent with the rejected filing and amend policies using approved forms.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-050, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-060 Filing authorization rules. An insurer may authorize a rating organization or a third-party filer to file forms on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing insurance regulatory compliance services.

(1) If an insurer delegates filing authority to a third-party filer, each filing must include a letter as supporting documentation signed by an officer of the insurer authorizing the third-party filer to make filings on behalf of the insurer.

(2) The insurer may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the insurer.

(3) If third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the insurer.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-060, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-070 Rating organization "bureau" rules. Under RCW 48.19.050, an insurer may authorize a bureau to file forms on its behalf. This section applies to members or subscribers that have granted filing authority to a bureau. Bureau members or subscribers must follow instructions provided by the bureau when they implement, delay or nonadopt a bureau form filing that has been approved by the commissioner. The insurer must make a filing with the commissioner if it delays the effective date, nonadopts or changes the bureau filing in any way. The filing must:

(1) Include a statement of changes proposed by the insurer;

(2) Provide the filing number used by the bureau when it filed the forms; and

(3) Be received by the commissioner in a timely manner.

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(4) For purposes of this section, "timely" means:

(a) Before the bureau effective date if the filing is made under RCW 48.18.100; or

(b) Thirty days after the bureau effective date if the filing is made under RCW 48.18.103.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-070, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-080 Use of rating organization "bureau" forms—No filing authorization. If a member or subscribing insurer has not authorized a bureau to file forms on its behalf, the insurer must make a filing with the commissioner to use bureau forms.

(1) If the forms are identical to the bureau forms, the filing must include this information:

(a) A statement by the insurer of its intent to use the bureau forms; and

(b) The filing number used by the bureau when it filed the forms.

(2) Insurers must independently file any forms that are not identical in content to approved bureau forms.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-080, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-090 Advisory organization rules. (1) Advisory organizations may file insurance forms with the commissioner. The commissioner will review advisory forms using the same standards that apply to insurers and rating organizations. If the forms comply with RCW 48.18.110, the commissioner will approve the forms on an advisory basis.

(2) If an insurer decides to use approved advisory forms, the insurer must make an independent form filing. The filing must include:

(a) A statement by the insurer of its intent to use the advisory forms;

(b) The filing number used by the advisory organization when it filed the forms; and

(c) Copies of the advisory forms attached to form schedule.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-090, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-100 Rules for responding to an objection letter. An objection letter may ask the filer to revise a noncompliant form or provide clarification or additional information about the form. If a form contains provisions that are contrary to RCW 48.18.110, the objection letter will state the reason(s) for disapproval, including relevant case law, statutes and administrative rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response includes:

(a) A separate response to each objection; and

(b) A description of changes proposed to noncompliant forms, and, if applicable, a replacement form or amendatory endorsement attached to the form schedule.

(2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-100, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-110 Applications and policyholder notices. RCW 48.18.190 says each form that conflicts with, modifies, or extends a contract of insurance must be in writing and made a part of the policy. Insurers must file these forms under RCW 48.18.100 or 48.18.103. Insurers must file applications and policyholder notices if the:

- (1) Application will be used under RCW 48.18.080; or
- (2) Policyholder notice amends or modifies policy provisions.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-110, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-120 Rules for revised or replaced insurance policy forms. If an insurer files a revised or replaced form, the filer must provide the supporting documentation described below:

(1) If a form is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the disapproved form.

(2) If a previously approved form is replaced with a new version, the filer must submit an exhibit that marks and identifies each change or revision to the replaced form using one of these methods:

- (a) A draft form that strikes through deletions and underlines additions or changes in the form;
- (b) A draft form that includes comments in the margins explaining the changes in the forms; or
- (c) A side-by-side comparison of current and proposed policy language.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-120, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-130 Effective date rules. (1) Filers must include a common effective date for all forms submitted in a filing. The insurer may use different effective dates for new and renewal policies if the filing includes this request and the policy includes a liberalization clause or condition.

(2) The proposed effective date must be a specific date.

(a) Vague statements, such as one that says the insurer will implement the filing thirty days after the commissioner's approval is not specific, and does not comply with this rule.

(b) If an insurer is filing a new program or optional endorsement, the filer may request an effective date concurrent with the commissioner's approval.

(3) The proposed effective date must be consistent with the law. Forms filed under RCW 48.18.103 must propose an effective date no more than thirty days before the date filed.

(4) If an insurer revises the effective date, the commissioner must receive this request in SERFF before the original effective date of the filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091, (Matter No. 2007-11) § 284-20B-130, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-140 Reference copies of amendatory endorsements. If an insurer will use a previously approved Washington amendatory endorsement with a new form, the filer must:

- (1) Provide a copy of the amendatory endorsement attached as supporting documentation; or

(2009 Ed.)

(2) Include the SERFF tracking number under which the endorsement was filed and approved in the filing description; and

(3) Explain how the insurer will use the amendatory endorsement with the new form.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-140, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-150 Rules for insurance policy forms translated from English to another language. Insurers may issue insurance policy forms written in languages other than English.

(1) If an insurer translates an insurance policy form from English to another language, the insurer must:

(a) File the translated version of the form with the commissioner.

(b) Include written disclosure statements on the translated policy form that the insurer is issuing the translated form on an informational basis and the English version is controlling for the purposes of application and interpretation. The disclosure statements must be in English and the language of the translated form and printed in bold face type of at least twelve-point font.

(c) Submit a certification with the filing by an officer employed by the insurer that the insurer will issue the English version of the policy form with the translated policy form.

(2) When filing a translated policy form, the filer must:

(a) Identify the approved English version of the policy form by providing, as applicable, the:

- (i) SERFF filing number;
- (ii) Form number, edition date or edition identifier; and
- (iii) Effective date of the filing.

(b) Submit certification by a professional translator certified by the American Translators Association or a comparable organization that the:

(i) Translator has translated the English version of the form; and

(ii) Translation is accurate.

(3) The commissioner will file but not review or approve translated insurance policy forms.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-150, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-160 Exemption for unauthorized insurers. Chapter 48.15 RCW applies to insurance transactions involving unauthorized surplus line insurers. Under RCW 48.18.100 (1)(e), insurance forms issued by unauthorized surplus line insurers are exempt from filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-160, filed 10/15/08, effective 2/1/09.]

WAC 284-20B-170 Exemption for insurance forms issued to large commercial property and casualty accounts. (1) Under RCW 48.18.103 (3)(a), the commissioner exempts forms issued to insure a large commercial property and casualty account from filing requirements under chapter 48.18 RCW.

(2) For purposes of this section, "large commercial property and casualty account" means property and casualty insurance as defined in WAC 284-24-001(10) that is pur-

chased by a business, not-for-profit organization, or public entity with enough insurance buying experience to negotiate with insurers in a largely unregulated environment and meets any two of the following criteria:

(a) Annual premiums of one hundred thousand dollars or more, excluding workers compensation insurance issued by the department of labor and industries and types of insurance listed in subsection (3) of this section;

(b) Net revenues or sales in excess of one hundred million dollars;

(c) More than two hundred employees;

(d) Net worth over fifty million dollars;

(e) Is a not-for-profit organization or public entity with an annual budget or assets of at least forty-five million dollars;

(f) Is a municipality with a population over fifty thousand.

(3) The exemption provided by this section does not apply to:

(a) Professional liability insurance policies, including all types of malpractice and errors and omissions insurance;

(b) Reimbursement insurance policies that indemnify service contract providers or protection product guarantee providers for contractual obligations assumed under a service contract or protection product guarantee; and

(c) Master policies under which insurers issue certificates of coverage to individual consumers, households, businesses, or other organizations.

(4) Before an insurer issues an insurance policy under this section, the insurer or its insurance producer must send written notice to the insured that says the:

(a) Insurer has not filed the forms with the commissioner; and

(b) Commissioner has not reviewed and approved the forms.

(5) The Washington insurance examining bureau will not audit property forms used to insure large commercial property and casualty accounts under WAC 284-20-006.

(6) If grounds exist under RCW 48.18.110(1), the commissioner may disapprove a form used to insure a large commercial property and casualty account. If the commissioner disapproves a form under RCW 48.18.110(1), the insurer must construe the form under the provisions of RCW 48.18.510.

(7) Each insurer must keep copies of forms used to insure large commercial property and casualty accounts for at least six years after the date the insurer issues a policy under this section. The insurer must make these records available to the commissioner upon request.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20B-170, filed 10/15/08, effective 2/1/09.]

Chapter 284-20C WAC

RULES FOR FILING MOTOR VEHICLE SERVICE CONTRACTS

WAC

284-20C-005	Definitions that apply to this chapter.
284-20C-010	Purpose of this chapter.
284-20C-020	General motor vehicle service contract filing rules.
284-20C-030	The commissioner may reject motor vehicle service contract filings.

284-20C-040	Rules for rejected filings made under RCW 48.110.073(3).
284-20C-050	Filing authorization rules.
284-20C-060	Rules for revised or replaced motor vehicle service contracts.
284-20C-070	Effective date rules.
284-20C-080	Reference copies of amendatory forms.
284-20C-090	Rules for responding to an objection letter.
284-20C-110	Rules for motor vehicle service contracts translated from English to another language.

WAC 284-20C-005 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter:

(1) "Complete filing" means a package of information containing motor vehicle service contracts, supporting information, documents and exhibits.

(2) "Contract" means a service contract covering motor vehicles, as described in chapter 48.110 RCW. Under this definition:

(a) "Motor vehicle" means the same as in RCW 48.110.020(11), and only includes vehicles that are self-propelled by a motor; and

(b) "Service contract" means the same as in RCW 48.110.020(16).

(3) "Date filed" means the date a complete motor vehicle service contract filing has been received and accepted by the commissioner.

(4) "Filer" means a person, organization or other entity that files motor vehicle service contracts with the commissioner.

(5) "Objection letter" means correspondence sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves a motor vehicle service contract under RCW 48.110.073.

(6) "Service contract provider" or "provider" means the same as in RCW 48.110.020(18).

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-005, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-010 Purpose of this chapter. (1) The purpose of this chapter is to adopt processes and procedures for providers and filers to use when they submit motor vehicle service contracts to the commissioner under RCW 48.110.073.

(2) This chapter is effective on February 1, 2009. All motor vehicle service contract filings received on or after February 1, 2009, must comply with this chapter.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-010, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-020 General motor vehicle service contract filing rules. Filers and providers must submit filings that comply with these rules:

(1) Filers must submit complete filings that comply with the filing instructions and procedures in the *Washington State Motor Vehicle Service Contract Filing Instructions* posted on the commissioner's web site (www.insurance.wa.gov), which the commissioner incorporates into this section by reference.

(2) Filers must submit every service contract to the commissioner in paper format with a completed motor vehicle service contract transmittal document.

(3) Filers must not combine "prior approval" and "use and file" contracts in one filing. Filers must file these types of contracts separately:

- (a) Contracts filed under RCW 48.110.073(2); or
- (b) Contracts filed under RCW 48.110.073(3).

(4) All filed contracts must be legible for both the commissioner's review and retention as a public record. Filers must submit new and replaced contracts to the commissioner for review in final printed form displayed in ten-point or larger type.

(5) Each contract must have a unique identifying number and a way to distinguish it from other editions of the same contract.

(6) Filers must submit a completed compliance checklist with each new motor vehicle service contract. If the filing includes more than one new contract, the filer may:

- (a) Complete a separate checklist for each motor vehicle service contract; or
- (b) Complete one checklist and submit an explanatory memorandum that lists any material differences between the filed contracts.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-020, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-030 The commissioner may reject motor vehicle service contract filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-20C-020. If the commissioner rejects a filing, the provider has not filed the service contract(s) with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-030, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-040 Rules for rejected filings made under RCW 48.110.073(3). (1) RCW 48.110.073(3) says contracts must be filed with the commissioner within sixty days after the provider first issues the contract to a consumer. If the commissioner rejects a filing under WAC 284-20C-030, the provider has not filed contracts with the commissioner.

(2) If the commissioner rejects a filing submitted under RCW 48.110.073(3) the:

- (a) Filer must promptly send a new filing to the commissioner within the original sixty-day use and file period in RCW 48.110.073(3); or
- (b) Provider must stop issuing motor vehicle service contracts sent with the rejected filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-040, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-050 Filing authorization rules. (1) A provider may authorize a third-party filer to file contracts on its behalf. Under this section, a "third-party filer" means:

- (a) An administrator as defined in RCW 48.110.020(1);

(2009 Ed.)

(b) An insurer; or

(c) A person or entity in the business of providing regulatory compliance services to providers.

(2) If a provider delegates filing authority to a third-party filer, each filing must include a letter signed by an employee of the provider authorizing the third-party filer to make filings on behalf of the provider. This subsection does not apply to a third-party filer that is an affiliate or wholly owned subsidiary of the provider.

(3) The provider may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the provider.

(4) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the provider.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-050, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-060 Rules for revised or replaced motor vehicle service contracts. If a provider files a revised or replaced contract, the filer must provide the supporting documentation described below:

(1) If a contract is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the disapproved contract.

(2) If a previously approved contract is replaced with a new version, the filer must submit an exhibit that marks and identifies each change or revision to the replaced contract using one of these methods:

- (a) A draft contract that strikes through deletions and underlines additions or changes in the contract;
- (b) A draft contract that includes comments in the margins explaining the changes in the contract; or
- (c) A side-by-side comparison of current and proposed contract language.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-060, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-070 Effective date rules. (1) Filers must include a common effective date for all contracts submitted in a filing.

(2) The proposed effective date must be a specific date.

(a) Vague statements, such as one that says the provider will implement a filing thirty days after the commissioner's approval is not specific, and does not comply with this rule.

(b) If a provider is filing a new program or optional coverage form, the filer may request an effective date concurrent with the commissioner's approval.

(3) The proposed effective date must be consistent with the law. Contracts filed under RCW 48.110.073(3) must propose an effective date no more than sixty days before the date filed.

(4) If the provider revises the effective date, the commissioner must receive the request before the original effective date of the filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-20C-070, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-080 Reference copies of amendatory forms. If a provider will use a previously approved Washington amendatory form with a new contract, the filer must:

- (1) Provide a copy of the amendatory form as supporting documentation; or
- (2) Provide the company tracking number from the contract filing under which the endorsement was filed and approved; and
- (3) Explain how the provider will use the amendatory form with the new contract.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-20C-080, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-090 Rules for responding to an objection letter. An objection letter may ask the filer to revise non-compliant contracts or provide clarification or additional information about the contract. If the commissioner finds that a contract contains provisions that are contrary to RCW 48.110.073, the objection letter will state the reason(s) for disapproval, including relevant case law, statutes and administrative rules. Filers must:

- (1) Provide a complete response to an objection letter. A complete response includes:
 - (a) A separate response to each objection; and
 - (b) A description of changes proposed to noncompliant contracts, and, if applicable, a replacement contract or amendatory form.
- (2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-20C-090, filed 10/15/08, effective 2/1/09.]

WAC 284-20C-110 Rules for motor vehicle service contracts translated from English to another language. Providers may issue motor vehicle service contracts written in languages other than English.

- (1) If a provider translates a contract from English to another language, the provider must:
 - (a) File the translated version of the contract with the commissioner.
 - (b) Include written disclosure statements on the translated contract that the provider is issuing the translated contract on an informational basis and the English version is controlling for the purposes of application and interpretation. The disclosure statements must be in English and the language of the translated contract and printed in bold face type of at least twelve-point font.
 - (c) Submit written certification by an officer employed by the provider that the provider will issue the English version of the contract with the translated contract.
- (2) When filing a translated policy form, the filer must:
 - (a) Identify the approved English version of the contract by providing, as applicable, the:
 - (i) Company tracking number under which the contract was filed;
 - (ii) Contract number, edition date or edition identifier; and
 - (iii) Effective date of the filing.
 - (b) Submit written certification by a professional translator certified by the American Translators Association or a comparable organization that the:

[Title 284 WAC—p. 136]

- (i) Translator has translated the English version of the contract; and
- (ii) Translation is accurate.
- (3) The commissioner will file but not review or approve translated motor vehicle service contracts.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-20C-110, filed 10/15/08, effective 2/1/09.]

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 representa-

(2009 Ed.)

tives, 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.

FORM REG.-335

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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

FORM REG.-335

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[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 net income or loss of the assigned risk plan is 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 and 48.22.070. 03-03-052 (Matter No. R 2001-10), § 284-22-020, filed 1/13/03, effective 2/13/03. 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 not terminate until all policies under the plan have expired and outstanding obligations incurred under such policies have been satisfied.

[Statutory Authority: RCW 48.02.060. 95-18-106, § 284-22-030, filed 9/6/95, effective 10/7/95; 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, been unable to purchase United States Longshore and Harbor Workers' Compensation Act coverage from authorized insurers writing such coverage in Washington. "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) "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.

(10) "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 and 48.22.070, 06-24-038 (Matter No. R 2006-09), § 284-22-050, filed 11/30/06, effective 12/31/06; 03-03-052 (Matter No. R 2001-10), § 284-22-050, filed 1/13/03, effective 2/13/03. 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' Act compensation insurance in Washington state, and for the state industrial insurance fund.

(2) Any assessments and distributions declared by the governing committee of the plan shall be allocated in accordance with RCW 48.22.070, fifty percent to the industrial insurance fund and fifty percent to the insurer participants as a group. Assessments and distributions shall be allocated amongst the eligible insurer participants according to their relative subject premium volumes as determined by the governing committee, subject to a reasonable de minimus premium threshold established by the governing committee for each assessment or distribution.

(3) For purposes of assessments and distributions, "subject premium" shall be for each authorized and eligible insurer its primary and excess written premiums for risks in the state of Washington covered under United States Longshore and Harbor Workers' Act compensation insurance, and maritime employer's liability insurance incidental to that workers' compensation insurance, for the relevant time periods as determined by the governing committee. If any insurer fails to provide its subject premium data in an accurate and timely manner upon request by the plan, the governing committee may, in its sole discretion, substitute that insurer's direct written premiums for workers' compensation reported or reportable in its statutory annual statement as statutory page fourteen data for the state of Washington, or the governing committee may, in its sole discretion, substitute a zero amount for that insurer.

(4) Timing and amount of assessments and distributions shall be at the discretion of the governing committee, subject to the commissioner's approval. Assessments shall be based upon a demonstrable need to obtain additional funds to safeguard the operations of the plan in a financially sound and responsible manner, including, but not limited to, fully funding all of the plan's current and long term financial obligations. The governing committee may request approval for distributions to plan participants from time to time, of surpluses incurred which exceed amounts deemed necessary by the governing committee to safeguard the operations of the plan in a financially sound and responsible manner, including, but not limited to, fully funding all of the plan's current and long term financial obligations. Notwithstanding any

prior distributions which may have been approved or directed by the commissioner, if the plan has been terminated by the legislature, then the plan shall be required to distribute, in accordance with RCW 48.22.070, any surplus of funds after payment or provision for payment of all of the plan's liabilities.

[Statutory Authority: RCW 48.02.060 and 48.22.070. 03-03-052 (Matter No. R 2001-10), § 284-22-060, filed 1/13/03, effective 2/13/03. 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

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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, and requests for distributions from time to time, upon receipt of evidence that such assessments are necessary, or such distributions are prudent, and that such assessments or distributions ensure the plan's continued operation in a financially sound and responsible manner.

[Statutory Authority: RCW 48.02.060 and 48.22.070. 03-03-052 (Matter No. R 2001-10), § 284-22-080, filed 1/13/03, effective 2/13/03. 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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284-23-120	Severability provision. [Order R-75-3, § 284-23-120, filed 8/22/75, effective 11/1/75.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
284-23-130	Effective date. [Order R-75-3, § 284-23-130, filed 8/22/75, effective 11/1/75.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
284-23-260	Effective date. [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.] Repealed by 98-11-003 (Matter No. R 97-04), filed 5/6/98, effective 6/6/98. Statutory Authority: RCW 48.02.020 and 48.30.010.
284-23-270	Life insurance buyer's guide, form to be used. [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.] Repealed by 98-11-003 (Matter No. R 97-04), filed 5/6/98, effective 6/6/98. Statutory Authority: RCW 48.02.020 and 48.30.010.
284-23-380	Effective date. [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.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
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.
284-23-645	Tax qualified accelerated benefit provisions. [Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-645, filed 2/6/98, effective 3/9/98.] Repealed by 08-24-023 (Matter No. R 2008-19), filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a).

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.

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(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.

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(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 licensing 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

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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.]

LIFE INSURANCE DISCLOSURE

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 the buyer's 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 Washington statute or regulation.

[Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-200, filed 5/6/98, effective 6/6/98. 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 for the exemptions specified in subsection (2) of this section, this regulation shall apply to any solicitation, negotiation or procurement of life

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insurance occurring within this state. This regulation shall apply to any issuer of life insurance contracts including fraternal benefit societies.

(2) Unless 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 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-210, filed 5/6/98, effective 6/6/98. 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*" is a document that contains, and is limited to, the current buyer's guide, which has been recommended for use by the National Association of Insurance Commissioners. A company must use the current *Buyer's Guide* no later than six months after approval by the National Association of Insurance Commissioners.

(2) Cost comparison indexes:

(a) "Surrender cost comparison index—Guaranteed basis" is calculated by applying the following steps:

(i) Step one: Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.

(ii) Step two: Divide the result of step one 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 one over the respective periods stipulated in step one. If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(iii) Step three: Determine the equivalent guaranteed level premium by accumulating each guaranteed annual premium payable for the basic policy or rider at five percent interest compounded annually to the end of the period stipulated in step one and dividing the result by the respective factors stated in step two. (This amount is the guaranteed annual premium payable for a level premium plan.)

(iv) Step four: Subtract the result of step two from step three.

(v) Step five: Divide the result of step four by the number of thousands of the equivalent guaranteed level death benefit, using the company's guaranteed rate schedule to determine the amount payable upon death for purposes of subsection (3) of this section, to arrive at the "surrender cost comparison index—Guaranteed basis."

(b) "Net payment cost comparison index—Guaranteed basis" is calculated in the same manner as the comparable "surrender cost comparison index—Guaranteed basis" except that the cash surrender value is set at zero.

(3) "Equivalent guaranteed level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

(a) Step six: Accumulate the 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) Step seven: Divide each accumulation of step six by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step six over the respective periods stipulated in step six. If the period is ten years, the factor is 13.207 and if the period is twenty years, the factor is 34.719.

(4) "Generic name" is a short title that is descriptive of the premium and benefit patterns of a policy or a rider.

(5) "Policy data" is a display or schedule of guaranteed numerical values for each policy year or a series of designated policy years of the following information: Premiums; death benefits; cash surrender values and endowment benefits.

(6) "Policy summary" is 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 guaranteed annual premium for the basic policy.

(ii) The guaranteed annual premium for each optional rider.

(iii) The 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) The guaranteed total cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(v) Any 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 adjustable, the policy summary shall also indicate that the annual percentage rate will be determined by the

company in accordance with the provisions of the policy and the applicable law.

(g) Cost comparison 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. The 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 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 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, 48.44.050, and 48.46.200. 08-03-127 (Matter No. R 2007-13), § 284-23-220, filed 1/23/08, effective 2/23/08. Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-220, filed 5/6/98, effective 6/6/98. 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 Duties of insurers. (1) The insurer shall provide a *Buyer's Guide* and a policy summary to any prospective purchaser upon request.

(2) The insurer shall provide, to all prospective purchasers, a *Buyer's Guide* prior to accepting the applicant's initial application, premium, or premium deposit.

(3) A policy summary must be delivered with or prior to delivery of a policy provided, however, that:

(a) If an illustration, subject to the requirements of chapter 48.23A RCW (Life insurance policy illustrations), is used in the sale of a policy, a policy summary does not have to be provided. Only guarantees may be shown in the policy summary for policies written with an application date on or after the effective date of chapter 48.23A RCW (Life insurance policy illustrations).

(b) If the policy for which application is made or its policy summary does not contain an unconditional refund provision of at least ten days, the policy summary must be delivered prior to delivery of the policy.

(c) If the equivalent guaranteed level death benefit of the policy for which application is made does not exceed five thousand dollars, 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 (6)(b), (c), (d), (e)(i), (ii), (iii), (iv), (f), (g), (h), and (i).

[Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-230, filed 5/6/98, effective 6/6/98. 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.]

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WAC 284-23-235 Special plans and solicitation by direct response. (1) In the case of a solicitation by direct response methods, the insurer shall provide a *Buyer's Guide* and a policy summary prior to accepting the application. However, if the policy contains an unconditional refund provision of at least ten days, the *Buyer's Guide* and a policy summary may be delivered with the policy.

(2) Special plans. This subsection modifies the application of this rule as indicated for certain special plans of life insurance:

(a) "Flexible premium and benefit policies." For policies sold without illustrations which:

(i) Permit the policyowner to vary the amount and timing of premium payments, or the amount payable on death, all indexes and other data shall be displayed assuming specific schedules of anticipated premiums and death benefits at issue.

(ii) Provide for a cash value that is based on separately identified interest credits and mortality and expense charges applied to the policy, then the policy summary shall indicate when the policy will expire based on the interest rates and mortality and other charges guaranteed in the policy and the anticipated or assumed annual premiums shown in the policy summary.

(b) "Multitrack policies." For policies which allow a policyowner to change or convert the policy from one plan or amount to another, the policy summary:

(i) Shall display all indexes and other data assuming that the option is not exercised; and

(ii) May display all indexes and other data using a stated assumption about the exercise of the option.

(c) "Policies with any rate subject to continued insurability." For policies which allow a policyowner a reduced premium rate if the insured periodically submits evidence of continued insurability, the policy summary:

(i) Shall display cost indexes and other data assuming that the insured always qualifies for the lowest premium;

(ii) Shall display cost indexes and other data assuming that the insured fails to qualify for the lowest premium and the company always charges the highest premiums allowable; and

(iii) Shall indicate the conditions that must be fulfilled for an insured to qualify periodically for the reduced rate.

[Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-235, filed 5/6/98, effective 6/6/98.]

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 under this regulation. The file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use unless otherwise provided by this regulation.

(2) An agent shall inform the prospective purchaser, prior to commencing any presentation that may lead to the sale of life insurance, that the agent is acting as a life insurance agent. 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 counselor shall not be used

by an agent unless the agent is generally engaged in an advisory business.

(4) There shall be no reference to a dividend or nonguaranteed element in the policy summary. Any reference to a dividend or a nonguaranteed element in the sales process must comply with the provisions of chapter 48.23A RCW.

(5) Any statement regarding the use of the life insurance cost comparison 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.

[Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-240, filed 5/6/98, effective 6/6/98. 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 or an agent to provide or deliver a *Buyer's Guide*, a policy summary, or policy data as provided under WAC 284-23-230 and 284-23-235 shall constitute an unfair method of competition and an unfair act or practice, under RCW 48.30.-010.

[Statutory Authority: RCW 48.02.020 and 48.30.010. 98-11-003 (Matter No. R 97-04), § 284-23-250, filed 5/6/98, effective 6/6/98. 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.]

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.

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(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.

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(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

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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.]

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.

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(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

(2009 Ed.)

(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.]

WAC 284-23-580 Insurer must obtain and keep evidence that insured is a key person—Definition of "key person." (1) If a business entity seeks to be the owner and beneficiary of a contract of life insurance on an employee, the insurer must obtain and keep evidence that the business entity had an "insurable interest" in the life of the insured as required by RCW 48.18.030(3) and that the insured was a "key person" at the time the contract was made.

(2) An insurer issuing employer-owned key person life insurance to a business entity shall establish and apply appropriate underwriting guidelines to ensure that the employees or other persons on whose lives key person life insurance policies are written are actually key persons.

(3) An insurer issuing employer-owned life insurance policies or certificates must keep or require the employer to keep throughout the period of insurance, evidence that the insured has applied for or consented to the contract in writing. Consent requirements include, but are not limited to RCW 48.18.030, 48.18.060, and 48.18.580.

(4) If a contract of insurance is entered into pursuant to an exchange under Section 1035 of the Internal Revenue Code, an insurer is not required to obtain a new consent by the insured employee (as required at RCW 48.18.580(2)) only if the insurer to be replaced provides the replacing insurer with a copy of the original signed consent.

(5) The term "key person" means a person that, during the year the contract was made, was:

- (a) A director;
- (b) A shareholder who owns more than five percent in value of the stock of the employer; or
- (c) A "highly compensated individual" or "highly compensated employee" within the meaning of Internal Revenue Code sections 414(q), 105(h) or 101(j), as applicable.

[Statutory Authority: RCW 48.02.060 and 48.18.586, 08-01-076 (Matter No. R 2004-03), § 284-23-580, filed 12/17/07, effective 1/17/08.]

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 com-

petition 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. No qualifying event as defined under WAC 284-23-620(3) changes the nature of the underlying life insurance policy. No accelerated benefits provision shall be called or marketed as long-term care as defined under RCW 48.83.020(5).

(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 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, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a), 08-24-023 (Matter No. R 2008-19), § 284-23-610, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020, 98-05-026 (Matter No. R 96-13), § 284-23-610, filed 2/6/98, effective 3/9/98. 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 certificate holder 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 as described in subsection (3) of this section; 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 a physician has certified is reasonably expected to result in death twenty-four months or less after the date of certification;

(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;

(e) Any condition which requires either community-based care or institutional care.

(4) "Community based care" means services including, but not limited to: (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; (f) respite care; (g) adult day health care services; or (h) other similar services furnished in a home-like or residential setting that does not provide overnight care. Such services shall be provided at any level of care.

(5) "Institutional care" means care provided in a hospital, nursing 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.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-023 (Matter No. R 2008-19), § 284-23-620, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-620, filed 2/6/98, effective 3/9/98. 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 may 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) Except with the prior written approval of the commissioner 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. The con-

tract or rider shall include a statement that the insured's accidental death benefit will not be affected by the acceleration of benefits.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-640, filed 2/6/98, effective 3/9/98. 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) The disclosure form shall include a disclosure statement. The disclosure statement shall be prominently displayed on the first page of the policy, rider, or certificate. 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."

(b) The disclosure statement must begin with the following statement: "This accelerated life benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care."

(c) The disclosure form 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 form 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 insurance solicited by an insurance producer, the insurance producer shall provide the disclosure form to the applicant before or at the time the application is signed. Written acknowledgement of receipt of the disclosure

statement shall be signed by the applicant and the insurance producer.

(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 form shall be contained in the certificate of coverage, and may be contained 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 twenty 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 per-

mitted 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, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-023 (Matter No. R 2008-19), § 284-23-650, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-650, filed 2/6/98, effective 3/9/98. 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 a qualifying event caused by an accident 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, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-660, filed 2/6/98, effective 3/9/98. 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 among 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 dis-

count 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.

(d) Any other financing option that the commissioner is satisfied is not contrary to the best interests of the public. No financing option shall be offered by any insurer without the prior written approval of the commissioner.

(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.

(3) In the case of an acceleration as defined at WAC 284-23-620 (3)(e), an insurer shall use only one of the finance options permitted in this section for any insurance policy or certificate. An insurer may not place a lien on the face amount of an insured's policy or certificate and at the same time discount the face amount or accumulation amount.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-690, filed 2/6/98, effective 3/9/98. 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

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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 is required, pursuant to RCW 48.18.100 and WAC 284-58-130.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-710, filed 2/6/98, effective 3/9/98. 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.

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. 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.

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[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-023 (Matter No. R 2008-19), § 284-23-730, filed 11/24/08, effective 12/25/08. Statutory Authority: RCW 48.02.060, 48.30.010 and 48.11.020. 98-05-026 (Matter No. R 96-13), § 284-23-730, filed 2/6/98, effective 3/9/98. 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

284-24-001	Definitions that apply to this chapter.
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284-24-016	The commissioner may reject filings.
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284-24-120	Rate filing requirements are suspended for large commercial accounts.

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.
284-24-015	Statistical plans and designation of statistical agents. [Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-015, filed 10/7/98, effective 11/7/98. 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, 48.19.080 and 48.19.370. 90-13-041 (Order R 90-5), § 284-24-015, filed 3/1/82.] Repealed by 06-13-035 (Matter No. R 2005-02), filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 48.02.060, 48.19.370.
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 284-24-001 Definitions that apply to this chapter. Unless otherwise specified in rule, the definitions in this section apply throughout this chapter:

(1) "Advisory organization" means an entity not licensed under RCW 48.19.180 that files advisory rates with the commissioner.

(2) "Complete filing" means a package of information containing rates, supporting information, documents and exhibits submitted to the commissioner electronically using the System for Electronic Rate and Form Filing (SERFF).

(3) "Date filed" means the date a complete filing has been received and accepted by the commissioner.

(4) "Filer" means a person, organization or other entity that files insurance rates with the commissioner for an insurer.

(5) "Insurance" means the same as in RCW 48.01.040.

(6) "Insurer" means an insurer defined in RCW 48.01-050 to which the commissioner has issued a certificate of authority under chapter 48.05 RCW.

(7) "Member" or "subscriber" means an insurer that has paid a rating organization for services under RCW 48.19.050, and includes service purchasers.

(8) "NAIC" means the National Association of Insurance Commissioners.

(9) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves the filing under RCW 48.19.100.

(10) "Property and casualty insurance" means these types of insurance:

(a) Property insurance defined in RCW 48.11.040;

(b) Marine and transportation insurance defined in RCW 48.11.050;

(c) Vehicle insurance defined in RCW 48.11.060;

(d) General casualty insurance defined in RCW 48.11-070; and

(e) Surety insurance defined in RCW 48.11.080.

(11) "Rate" or "rates" means all classification manuals, loss costs, rate or rule manuals, rating plans, rating schedules, minimum rates, class rates, and rating rules that insurers must file under RCW 48.19.040 and 48.19.043.

(12) "Rating organization" or "bureau" means an entity licensed under RCW 48.19.180 that files rates on behalf of its members, subscribers, or service purchasers.

(13) "SERFF" means the System for Electronic Rate and Form Filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(14) "Type of insurance" means a specific type of insurance listed in the *Uniform Property and Casualty Product Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-001, filed 10/15/08, effective 2/1/09.]

WAC 284-24-005 Purpose and scope of this chapter. The purpose of this chapter is to adopt processes and procedures for insurers and filers to use when they submit property

and casualty insurance rates and rules with the commissioner under chapter 48.19 RCW. This chapter:

(1) Applies to insurers, advisory organizations and rating organizations that file property or casualty insurance rates under RCW 48.19.040 and 48.19.043; and

(2) Does not apply to insurers or insurance scoring model vendors that file insurance scoring models under RCW 48.19.035 and chapter 284-24A WAC.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-005, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-005, filed 10/7/98, effective 11/7/98.]

WAC 284-24-007 Filing documents incorporated by reference into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* posted on the SERFF web site (www.serff.com); and

(2) The *Washington State SERFF Property and Casualty Rate Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-007, filed 10/15/08, effective 2/1/09.]

WAC 284-24-011 General rate filing rules. Effective February 1, 2009, filers must submit complete rate filings that comply with the *SERFF Industry Manual* posted on the SERFF web site (www.serff.com) and the *Washington State SERFF Property and Casualty Rate Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov). All rate filings must comply with these rules:

(1) Filers must submit all rate filings and related documents to the commissioner electronically using SERFF.

(2) Filers must send all written correspondence related to a rate filing in SERFF.

(3) Each rate filing must be:

(a) Accurate and internally consistent; and

(b) Submitted separately by type of insurance.

(4) Filers must not submit combined rate and form filings.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-011, filed 10/15/08, effective 2/1/09.]

WAC 284-24-016 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-24-011. If the commissioner rejects a filing, the insurer has not filed rates with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-016, filed 10/15/08, effective 2/1/09.]

WAC 284-24-021 Rules for rejected rate filings made under RCW 48.19.043. RCW 48.19.043(2) says an insurer

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must file rates within thirty days after the date the insurer first uses them. If the commissioner rejects a filing under WAC 284-24-016, the insurer has not filed rates with the commissioner. If the commissioner rejects a filing submitted under RCW 48.19.043, the:

(1) Filer must promptly send a new rate filing to the commissioner within the original thirty-day use and file period in RCW 48.19.043(2); or

(2) Insurer must stop using the rates sent with the rejected filing and amend policies using approved rates.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-021, filed 10/15/08, effective 2/1/09.]

WAC 284-24-041 Filing authorization rules. An insurer may authorize a rating organization or third-party filer to file rates on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing insurance regulatory compliance services.

(1) If an insurer delegates filing authority to a third-party filer, each filing must include a letter as supporting documentation signed by an officer of the insurer authorizing the third-party filer to make filings on behalf of the insurer.

(2) The insurer may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the insurer.

(3) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the insurer.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-041, filed 10/15/08, effective 2/1/09.]

WAC 284-24-046 Rating organization "bureau" rules. Under RCW 48.19.050, an insurer may authorize a bureau to file rates on its behalf. This section applies to members or subscribers that have granted filing authority to a bureau.

(1) Bureau members or subscribers must follow instructions provided by the bureau when they implement, delay or nonadopt a bureau rate filing that has been approved by the commissioner.

(2) If the insurer has authorized the rating organization to make filings on its behalf, the insurer is not required to file new bureau rates with the commissioner, except as provided under WAC 284-24-062.

(3) The insurer must make a filing with the commissioner if an insurer delays the effective date, nonadopts or changes a filing in any way. The filing must:

(a) Include a statement of the changes proposed by the insurer;

(b) Provide the filing number used by the bureau when it filed rates with the commissioner; and

(c) Be received by the commissioner in a timely manner.

(4) Under this section, "timely" means:

(a) Before the bureau effective date if the filing is made under RCW 48.19.040; or

(b) Thirty days after the bureau effective date if the filing is made under RCW 48.19.043.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-046, filed 10/15/08, effective 2/1/09.]

WAC 284-24-049 Rules that apply to advisory organizations. (1) Advisory organizations may file rates with the commissioner. The commissioner will review the advisory rates using the same standards that apply to insurers and rating organizations. If the rates comply with chapter 48.19 RCW, the commissioner will approve the rates on an advisory basis.

(2) If an insurer wants to use approved advisory rates, the insurer must make a rate filing that includes:

(a) A statement by the insurer of its intent to use the advisory rates;

(b) The filing number used by the advisory organization when it submitted the filing; and

(c) Statistical and actuarial support for each component of the rate filing that is not part of the advisory filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-049, filed 10/15/08, effective 2/1/09.]

WAC 284-24-051 Rules for responding to objection letters. If the commissioner disapproves a filing under RCW 48.19.100, the objection letter will state the reason(s) for disapproval, including relevant law and administrative rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response includes:

(a) A separate response to each objection; and

(b) If appropriate, revised exhibits and supporting documentation.

(2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-051, filed 10/15/08, effective 2/1/09.]

WAC 284-24-060 Suspension of filing requirements for surplus lines insurance. Under RCW 48.19.080, the rate filing requirements in chapter 48.19 RCW are suspended for surplus line coverages. Insurers are not required to file rates for surplus line insurance policies placed in this state under chapter 48.15 RCW.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-060, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-060, filed 10/7/98, effective 11/7/98. 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 284-24-062 Loss cost filing rule. (1) The following definitions apply to this rule:

(a) "Prospective loss cost" means that portion of a rate that:

(i) Provides only for losses and loss adjustment expenses;

(ii) Does not provide for expenses or profit; and

(iii) 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.

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(b) "Loss cost adjustment" means a factor by which prospective loss costs are multiplied to obtain final rates. A loss cost adjustment must take 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; and

(vi) Other relevant factors, if any.

(c) "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, before application of individual risk variations permitted under WAC 284-24-100. Under this definition, a rate does not include minimum premiums or supplementary rating information.

(d) "Supplementary rating information":

(i) Means any manual or plan of policy writing rules, rating rules, classification system, territory codes and descriptions, rating plans, or any other similar information needed to determine the premium that applies to an insured; and

(ii) Includes factors and relativities, such as increased limits factors, package modification factors, classification relativities, and deductible relativities.

(2) Under RCW 48.19.080, the commissioner may modify the rate filing requirements in chapter 48.19 RCW. This rule modifies the rate filing requirements to permit rating and advisory organizations to make reference filings of prospective loss costs.

(a) Prospective loss costs filings must contain statistical data and supporting information for all calculations and assumptions underlying the prospective loss costs, but do not need to provide the information required by RCW 48.19.040 (2)(b) and (c). Prospective loss costs filings must be approved by the commissioner before use by any insurer as a reference document.

(b) To use rates based on loss costs, a member or subscriber must make a loss cost adjustment filing, under the applicable provisions of RCW 48.19.040 or 48.19.043. The filer must attach completed copies of these forms to the supporting documentation tab:

(i) A Washington Reference Filing Adoption Form;

(ii) A Washington Summary of Supporting Information Form for each loss cost adjustment factor; and

(iii) For each loss cost adjustment with which an expense constant is used, a Washington Expense Constant Supplement.

(c) A member or subscriber may use rates based on the bureau's or advisory organization's prospective loss costs without complying with the requirements of RCW 48.19.040 and 48.19.043 if the:

(i) Commissioner has approved the loss cost reference document;

(ii) Insurer has an approved loss cost adjustment on file with the commissioner and proposes no changes to it; and

(iii) Insurer will begin using the prospective loss costs on the date proposed by the rating organization and approved by the commissioner.

(2009 Ed.)

(d) After the commissioner has approved a loss cost reference document filing for an advisory organization or bureau and the filing has become effective, the new prospective loss costs supersede all earlier loss cost filings by that organization. Insurers must not make loss cost adjustment filings using prospective loss costs that have been superseded.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-062, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-062, filed 10/7/98, effective 11/7/98.]

WAC 284-24-065 Demonstration that rates satisfy the requirements of RCW 48.19.020. (1) When an insurer or rating organization files rates with the commissioner, it must demonstrate that the proposed rates satisfy the requirements of chapter 48.19 RCW. RCW 48.19.020 requires that premium rates for insurance are not 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.

(2) For the purposes of this section, "operating ratio" means 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.

(3) 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 must be included in the expected underwriting profit or loss.

(4) The commissioner will not consider rates excessive if the expected operating ratio corresponding to the proposed rate level is less than or equal to five percent.

(5) The commissioner will not consider rates inadequate if the expected operating ratio corresponding to the proposed rate level is greater than or equal to zero.

(6) When an insurer, advisory organization, or rating organization files rates for which the expected operating ratio corresponding to the proposed rate level is less than zero or greater than five percent, it must demonstrate that the proposed rates are consistent with the principles stated in subsection (1) of this section. In other words, the insurer or rating organization must show how it has accounted for all expected costs, including claims, claim settlement expenses, operational and administrative expenses, and the cost of capital.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-065, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.020, 48.19.080. 05-22-061 (Matter No. R 2003-05), § 284-24-065, filed 10/31/05, effective 1/1/06. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-065, filed 10/7/98, effective 11/7/98. 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 Rules for risks if there are no rate manuals. (1) Under RCW 48.19.080, the commissioner may waive insurance rate filing requirements in chapter 48.19 RCW. Except as described in subsection (2) of this section, the commissioner will waive rate filing requirements for indi-

vidual risks or classes of insurance for which the insurer has no classification plan, rate, guide rate, range of rates or rating rule. This section applies to these classes of insurance:

(a) A class in which risks are so different from each other that no rate or range of rates could be representative of all;

(b) A class that does not develop enough loss experience to warrant any credibility for ratemaking purposes; or

(c) Policies involving a new product or coverage for which there is no appropriate analogy to similar exposures for ratemaking purposes.

(2) A rating rule for the classes of insurance described in subsection (1) of this section must be filed with the commissioner. The rating rule must display the symbol "(a)" or include a statement that risks in the class must be submitted to the insurer for rating.

(3) The insurer's rating of a refer-to-company risk must be based on a documented underwriting analysis of:

(a) Specific characteristics related to potential for loss;

(b) Analogy to similar exposures; and

(c) Available loss frequency and severity data.

(4) Examples of unclassified risks for which "(a)" or refer-to-company rating is appropriate 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 risks subject to this section must keep separate documentation, including loss experience, on each risk written and must provide the documentation to the commissioner upon request.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-070, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-070, filed 10/7/98, effective 11/7/98. 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 rule for inland marine risks. Under RCW 48.19.030 and 48.19.070, insurers are not required to file rates with the commissioner for certain inland marine risks that are not written according to manual rates or rating plans. The following inland marine classes of risks, which are characterized by large numbers of insureds and homogeneous loss exposure, are written according to manual rates or rating plans and must be filed under chapter 48.19 RCW. Manual rates, classification or rating plans that apply to the following types of risks must be filed with the commissioner:

- (1) Accounts receivable coverage;
- (2) Agricultural machinery, farm equipment and livestock coverage;
- (3) Bicycle floater;
- (4) Boatowners' insurance or coverage for pleasure boats twenty-six feet and under in length;
- (5) Camera floater;
- (6) Camera and musical instrument dealers;
- (7) Commercial articles coverage (photographic equipment and musical instruments);
- (8) Communications equipment, including cell phones, pagers, and portable personal computers;
- (9) Equipment dealers coverage;
- (10) Film coverage form;
- (11) Fine arts private collections;
- (12) Floor plan merchandise coverage;
- (13) Fur dealers;
- (14) Hardware dealers;
- (15) Implement dealers;
- (16) Garment contractors;
- (17) Golfer's equipment floater;
- (18) Jewelry dealers;
- (19) Mail coverage;
- (20) Personal articles floater;
- (21) Personal effects floater;
- (22) Personal furs or fur floater;
- (23) Personal jewelry or jewelry floater;
- (24) Personal property floater;
- (25) Physicians' and surgeons' equipment coverage;
- (26) Signs coverage;
- (27) Silverware floater;
- (28) Stamp and coin collection floater;
- (29) Travel coverage other than accident and sickness;
- (30) Valuable papers and records; and
- (31) Wedding presents.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-080, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-080, filed 10/7/98, effective 11/7/98. 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 Schedule rating plan rules. (1) An insurer may file a schedule rating plan for the following monoline or packaged types or subtypes of insurance:

- (a) Commercial automobile;
- (b) Commercial crime;
- (c) Commercial fidelity and surety;
- (d) Commercial general liability;
- (e) Commercial inland marine;
- (f) Commercial multiperil; and
- (g) Commercial property.

(2) A schedule rating plan must provide for no more than a twenty-five percent credit (reduction) or debit (charge). A schedule rating plan must not be combined with other rating plans or rating rules in such a way that the schedule rating affects the premium by more than twenty-five percent.

(3) If an expense modification rule does not prescribe specific credits or debits for particular situations the commissioner will consider it similar to schedule rating. In this case, the combined effect of schedule and expense modifications must not exceed twenty-five percent.

(4) If an expense modification plan prescribes specific credits for particular situations, such as various premium size ranges or commission levels, the insurer is not required to include these credits or debits in the twenty-five percent schedule rating maximum.

(5) A schedule rating plan must provide for an objective analysis or risk by the insurer and be based on specific information that support the rating decision. An insurer may consider these types of risk factors:

- (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.

(6) If a risk is rated below average (debited) under a schedule rating plan, the insurer must advise an insured or applicant, upon timely request, of the factors that led to the adverse rating so that the insured or applicant can take appropriate corrective action.

(7) The insurer must administer each schedule rating plan equitably and apply it fairly to every eligible applicant or insured.

(8) The insurer must keep documentation that supports the development of individual risk modifications for the later of three years or the end of the next regular examination conducted by its home state insurance regulator.

(a) The insurer must make these documents available for examination by the commissioner upon request.

(b) The records must include copies of all documentation used in the development of each individual risk modification, even if a credit or debit does not result.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-100, filed 10/15/08, effective 2/1/09. Statutory Authority:

ity: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-100, filed 10/7/98, effective 11/7/98. 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.]

WAC 284-24-110 An insurer must make a rate filing to change zip code boundaries. (1) An insurer must not change an insured's rates solely because the insured's zip code has been changed by the United States Postal Service. This section does not prohibit insurers from using zip codes to define rating territories.

(2) The zip code boundaries approved by the commissioner determine the physical boundaries of each territory. The insurer must make a new rate filing to change the physical boundaries of a rating territory.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-110, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.19.080, 48.19.370 and 48.19.020. 98-20-102 (Matter No. R 98-4), § 284-24-110, filed 10/7/98, effective 11/7/98.]

WAC 284-24-115 Effective date rules. (1) Filers must include a common effective date for all rates submitted in a filing. If a filer includes a request in the filing, an insurer may use a different effective date for renewal policies, subject to a maximum interval of sixty days.

(2) The proposed effective date must be a specific date.

(a) Vague statements, such as one that says the insurer will implement a filing thirty days after approval is not specific, and does not comply with this section.

(b) If an insurer is filing a new program or optional coverage, the filer may request an effective date concurrent with the commissioner's approval.

(3) The proposed effective date must be consistent with Washington law. Rates filed under RCW 48.19.043 must propose an effective date no more than thirty days before the date filed.

(4) If an insurer revises the effective date of a filing, the commissioner must receive the request in SERFF before the original effective date of the filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-115, filed 10/15/08, effective 2/1/09.]

WAC 284-24-120 Rate filing requirements are suspended for large commercial accounts. (1) Under RCW 48.19.080, the commissioner will suspend the rate filing requirements in chapter 48.19 RCW for large commercial property and casualty accounts.

(2) For purposes of this section, "large commercial property and casualty account" means property and casualty insurance as defined in WAC 284-24-001(10) that is purchased by a business, not-for-profit organization, or public entity with enough insurance buying experience to negotiate with insurers in a largely unregulated environment and that meets any two of the following criteria:

(a) Annual premiums of one hundred thousand dollars or more, excluding workers compensation insurance issued by the department of labor and industries and types of insurance listed in subsection (6) of this section;

(b) Net revenues or sales in excess of one hundred million dollars;

(c) More than two hundred employees;

(2009 Ed.)

(d) Net worth over fifty million dollars;

(e) Is a not-for-profit organization or public entity with an annual budget or assets of at least forty-five million dollars;

(f) Is a municipality with a population over fifty thousand.

(3) Before an insurer issues coverage under this section, the insurer or its insurance producer must notify the insured in writing that the rates have not been and will not be filed with the commissioner for approval.

(4) The Washington Insurance Examining Bureau will not audit rates used on large commercial property casualty accounts under WAC 284-20-006.

(5) The commissioner may examine rates used for pricing large commercial property and casualty accounts to determine if they meet the requirements of chapter 48.19 RCW and Title 284-24 WAC. If an insurer relies on this section to issue a policy, the insurer must keep supporting documentation for the underlying rates and final premium determination for a minimum of three years after the policy is issued and make it available to the commissioner upon request.

(6) Subsection (1) of this section does not apply to:

(a) Professional liability insurance, including all types of malpractice and errors and omissions insurance;

(b) Reimbursement insurance policies that indemnity service contract providers or protection product guarantee providers for contractual obligations assumed under a service contract or protection product guarantee; and

(c) Master policies under which certificates of coverage are issued to individual consumers, households, businesses, or other organizations.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-24-120, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060 and 48.19.080. 07-09-085 (Matter No. R 2006-12), § 284-24-120, filed 4/17/07, effective 5/18/07. Statutory Authority: RCW 48.02.060, 48.18.100(6), and 48.19.080. 04-01-175 (Matter No. R 2003-04), § 284-24-120, filed 12/23/03, effective 1/23/04. Statutory Authority: RCW 48.02.060, 48.18.100, 48.19.080. 02-02-068 (Order R 2001-09), § 284-24-120, filed 12/28/01, effective 12/31/01. Statutory Authority: RCW 48.02.060 and 48.19.080. 99-23-068 (Matter No. R 99-5), § 284-24-120, filed 11/15/99, effective 12/16/99.]

Chapter 284-24A WAC

RULES THAT APPLY TO INSURERS THAT USE CREDIT HISTORY FOR PERSONAL INSURANCE UNDERWRITING OR RATING

WAC

284-24A-001	What is the purpose of these rules?
284-24A-005	What definitions are important to these rules?
284-24A-010	What must an insurer tell a consumer when it takes an adverse action?
284-24A-011	What types of information must an insurer provide in addition to the reason(s) for the adverse action to comply with WAC 284-24A-010(2)?
284-24A-012	What types of reasons do not provide enough information to adequately explain an adverse action?
284-24A-015	When must an insurer file the insurance scoring model to comply with the law?
284-24A-020	How should an insurance scoring model be filed?
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284-24A-030	How will an insurer or vendor know its insurance scoring model will remain confidential and proprietary?
284-24A-032	Under RCW 48.19.035 (2)(b) what does "eligibility rules or guidelines" mean?

284-24A-033	How will an insurer or a group of affiliated insurers know its eligibility rules or guidelines will be withheld from public inspection?
284-24A-035	What will the commissioner do with the insurance scoring model after he or she receives it?
284-24A-040	What action will the commissioner take if a model does not comply with Washington law?
284-24A-045	If an insurer uses credit history or insurance scores to segment personal insurance business for rating purposes, how can the insurer show that its rating plan results in premium rates that are not excessive, inadequate, or unfairly discriminatory?
284-24A-050	What types of information must an insurer include in a multivariate analysis?
284-24A-055	Should an insurer submit actuarial data based on demographic factors with an insurance scoring model or with a rate filing?
284-24A-065	Questions and answers.

WAC 284-24A-001 What is the purpose of these rules? These rules describe the standards that apply to insurers that use underwriting criteria or rating plans for personal insurance based on credit history. The rules have been adopted under the authority and purposes of the following laws: RCW 48.02.060; chapters 48.18; 48.19; and 48.30 RCW.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-001, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-005 What definitions are important to these rules? "Demographic factors" means the factors listed below if they are used in an insurer's rates, rating tiers, rating factors, rating rules or risk classification plan:

- Age of the insured;
- Sex of the insured;
- The rating territory assigned to the property location for residential property insurance and to the vehicle's garage location for personal auto insurance.

"Premium" means the same as RCW 48.18.170.

"Rate" means the cost of insurance per exposure unit.

"Rating factor" means a number used to calculate premium.

"Risk classification plan" means a plan to formulate different premiums for the same coverage based on group characteristics.

"Significant factor" means an important element of a consumer's credit history or insurance score. Examples of significant factors include:

- Bankruptcies, judgments, and liens;
- Delinquent accounts;
- Accounts in collection;
- Payment history;
- Outstanding debt;
- Length of credit history; and
- Number of credit accounts.

"Substantive underwriting factor" means a factor that is very important to an underwriting decision. Examples of substantive underwriting factors include:

- History of filing claims;
 - History of moving violations or accidents;
 - History of driving uninsured;
 - Type of performance for which a vehicle is designed;
- and
- Maintenance of a structure to be insured.

"Vehicle" means any motorized vehicle that can be insured under a private passenger auto insurance policy.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-005, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-005, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-010 What must an insurer tell a consumer when it takes an adverse action? (1) An insurer must tell a consumer about significant factors that adversely affect the consumer's credit history or insurance score. As many as four factors may be needed to explain the adverse action.

(2) An insurer must explain what significant factors led to an adverse action as defined in RCW 48.18.545 (1)(a). The insurer is responsible for making sure that the reason(s) an adverse action occurred is written in reasonably clear and simple language, even if the reason(s) is provided to the insurer by a vendor.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-010, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-010, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-011 What types of information must an insurer provide in addition to the reason(s) for the adverse action to comply with WAC 284-24A-010(2)? (1) Insurers must provide information that helps the consumer determine why the consumer was charged a higher premium or determined to be ineligible for coverage by the insurer. The following information must be included with the reason for the adverse action:

(a) A description of the attribute of credit history that adversely affected the consumer's insurance score;

(b) How the attribute of credit history affected the insurance score; and

(c) Any actions that are available to the consumer that may improve this attribute of the insurance score.

(2) If an insurer refers to insurance industry research or studies to justify the effect of an insurance score on premiums or eligibility for coverage, the insurer must file those studies with the insurance commissioner so that they are available for public disclosure.

[Statutory Authority: RCW 48.02.060 and 48.18.545. 07-14-103 (Matter No. R 2007-03), § 284-24A-011, filed 7/2/07, effective 8/2/07. Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-011, filed 12/29/04, effective 7/1/05.]

WAC 284-24A-012 What types of reasons do not provide enough information to adequately explain an adverse action? An insurer must explain any adverse action in reasonably clear and simple language. Insurers must not use phrases that do not explain why the consumer was charged a higher premium or determined to be ineligible for coverage by the insurer.

(1) Explanations of adverse actions that do not meet this standard include, but are not limited to:

(a) Unfavorable length of credit history.

(b) Absence of revolving credit account.

- (c) Age of oldest account or revolving credit account.
- (d) Age that consumer first opened a credit account.
- (e) Unfavorable number of bank or revolving accounts.
- (f) Unfavorable debt ratio.
- (g) Unfavorable number of accounts opened in past year.

(2) Insurers must not use the term "unfavorable" to describe an attribute of credit history because it does not provide clear information to the consumer about their credit history.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-012, filed 12/29/04, effective 7/1/05.]

WAC 284-24A-015 When must an insurer file the insurance scoring model to comply with the law? (1) Every insurer that uses an insurance scoring model to underwrite personal insurance coverage must file the model with the commissioner before January 1, 2003.

(2) Every insurer that uses an insurance scoring model to determine personal insurance rates or premiums must file the model with the commissioner before June 30, 2003. Related rates, risk classification plans, rating factors and rating plans must be filed and approved by June 30, 2003.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-015, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-020 How should an insurance scoring model be filed? (1) Insurance scoring models must be filed separately. The model must not be filed with any rate or rule filing.

(2) The insurance scoring model must be filed with the current transmittal form accepted by the commissioner. A copy is available at <http://www.insurance.wa.gov/> or by contacting the rates and forms division.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-020, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-025 Will the commissioner accept filings by insurance scoring model vendors? (1) The commissioner will allow vendors to file insurance scoring models.

(2) Insurers may use models filed by vendors after the commissioner determines the model complies with Washington state laws.

(3) An insurer may use a model that has been filed by a vendor and accepted by the commissioner if the insurer:

- (a) Submits a transmittal form; and
- (b) A cover letter that:
 - (i) References the vendor that filed the model;
 - (ii) References the filing number used by the vendor;
 - (iii) States whether the insurance scoring model will be used for underwriting, rating, or both; and

(iv) Proposes an effective date for the insurer's use of the model.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-025, filed 9/6/02, effective 10/7/02.]

(2009 Ed.)

WAC 284-24A-030 How will an insurer or vendor know its insurance scoring model will remain confidential and proprietary? (1) The law says insurance scoring models will remain confidential unless the commissioner is taking an enforcement action. An insurer or vendor may request that its insurance scoring model be available for public inspection.

(2) The transmittal form has a box an insurer or vendor may check if it wants the model to remain confidential.

(a) If the box is checked "yes," the model will be withheld from public inspection.

(b) If the box is checked "no," the model will be available for public inspection.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-030, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-032 Under RCW 48.19.035 (2)(b) what does "eligibility rules or guidelines" mean? "Eligibility rules or guidelines" mean rules that determine whether a consumer is eligible for insurance from a single insurer or a group of affiliated companies. Eligibility rules or guidelines do not include rules that determine which company within an affiliated group of companies a consumer will be placed based on their insurance score or other underwriting criteria.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-032, filed 12/29/04, effective 7/1/05.]

WAC 284-24A-033 How will an insurer or a group of affiliated insurers know its eligibility rules or guidelines will be withheld from public inspection? Eligibility guidelines will be kept as confidential records if they:

- (1) Conform to the definition in WAC 284-24A-032; and
- (2) Are clearly identified.

To ensure confidentiality, insurers should submit eligibility guidelines in a separate and distinct part of the related rate filing so they may be separated from other documents in the filing that are public records under RCW 48.19.040(5).

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-033, filed 12/29/04, effective 7/1/05.]

WAC 284-24A-035 What will the commissioner do with the insurance scoring model after he or she receives it? Actuarial analysts will review the model to determine whether it complies with Title 48 RCW. The scope of the review will include whether the model includes:

- (1) Any prohibited factors; and
- (2) Attributes that may result in unfair discrimination.

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5). 02-19-013 (Matter No. R 2001-11), § 284-24A-035, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-040 What action will the commissioner take if a model does not comply with Washington law? The commissioner will:

- (1) Notify the insurer or vendor that the model does not comply with Washington law;
- (2) State the reasons why the model does not comply with Washington law;

(3) Offer the insurer or vendor sixty days to revise the model to resolve the issue(s) outlined in subsection (2) of this section; and

(4) Provide a specific date when the model may no longer be used in Washington if the model has not been revised to resolve the issue(s).

[Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5), 02-19-013 (Matter No. R 2001-11), § 284-24A-040, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-045 If an insurer uses credit history or insurance scores to segment personal insurance business for rating purposes, how can the insurer show that its rating plan results in premium rates that are not excessive, inadequate, or unfairly discriminatory? If an insurer uses credit history or insurance scores to segment personal insurance business for rating purposes, the insurer must:

(1) Submit a multi variate analysis with the first rate and rule filing the insurer makes to comply with this law.

(2) Submit a multivariate analysis any time the insurer uses credit history or an insurance score to revise a risk classification plan, rating factor, rating plan, rating tier, or base rates.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.-010. 05-02-026 (Matter No. R 2004-01), § 284-24A-045, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.-120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.-035(5), 02-19-013 (Matter No. R 2001-11), § 284-24A-045, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-050 What types of information must an insurer include in a multivariate analysis? (1) A multivariate statistical analysis must evaluate the rating factors listed below (if applicable to the rating plan, and to the extent that data are credible):

(a) For homeowners, dwelling property, earthquake, and personal inland marine insurance:

- (i) Insurance score;
- (ii) Territory and/or geographic area;
- (iii) Protection class;
- (iv) Amount of insurance;
- (v) Surcharges or discounts based on loss history;
- (vi) Number of family units; and
- (vii) Policy form relativity.

(b) For private passenger automobile, personal liability and theft, and mechanical breakdown insurance:

- (i) Insurance score;
- (ii) Driver class;
- (iii) Multicar discount;
- (iv) Territory and/or geographic area;
- (v) Vehicle use;
- (vi) Rating factors related to driving record; and
- (vii) Surcharges or discounts based on loss history.

(2) An insurer must provide a general description of the model used to perform the multivariate analysis, including the:

- (a) Formulas the model uses;
- (b) Rating factors that are included in the modeling process; and
- (c) Output from the model, such as indicated rates or rating factors.

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(3) An insurer must show how the proposed rates or rating factors are related to the multivariate analysis.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.-010. 05-02-026 (Matter No. R 2004-01), § 284-24A-050, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.-120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.-035(5), 02-19-013 (Matter No. R 2001-11), § 284-24A-050, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-055 Should an insurer submit actuarial data based on demographic factors with an insurance scoring model or with a rate filing? (1) Insurers should not submit actuarial data based on demographic factors with their insurance scoring model.

(2) Insurers must submit actuarial data based on demographic factors to support any difference in rates or premiums based on:

(a) "No hit," which means the absence of credit history; or

(b) "No score," which means the inability to determine the consumer's credit history.

(3) The actuarial data must include:

(a) Loss history for an experience period acceptable to the commissioner. The length of the experience period will be determined by the amount of data available to the insurer.

(b) Earned exposures.

(c) Earned premiums.

(d) An analysis of the credibility of the data.

(4) The actuarial data must be segmented by:

(a) Demographic factors, which may be grouped in broader categories in a manner acceptable to the commissioner;

(b) "No hit"; and

(c) "No score."

(5) The actuarial data must show that the proposed rates, rating factors, rating rules, or risk classification plans relating to "no hit" and "no score" comply with RCW 48.19.020.

(6) These filings are subject to prior approval by the commissioner under the provisions of RCW 48.19.040.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.-010. 05-02-026 (Matter No. R 2004-01), § 284-24A-055, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.-120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.-035(5), 02-19-013 (Matter No. R 2001-11), § 284-24A-055, filed 9/6/02, effective 10/7/02.]

WAC 284-24A-065 Questions and answers. (1) **Our insurance company uses insurance scoring bands (a range of scores) to determine what to charge a consumer based on their personal insurance score. Does an insurer have to file its insurance scoring bands?** Yes. If an insurer uses insurance scoring bands for rating purposes, the insurer must file them (and any future changes to those bands). The bands are part of the rating plan and must be supported by actuarial analysis.

(2) **What types of data can an insurer use to support a credit-based rating plan?** A credit-based rating plan must be based on the experience of the insurer, an affiliated insurer under the same management, or a licensed rating organization. The commissioner will accept data from other states where comparable credit-based rating plans are in effect.

(2009 Ed.)

(3) **The law says an insurer cannot use the number of credit inquiries to set rates or to deny insurance. Can an insurer consider the amount of time since the most recent inquiry?** Yes. The law prohibits an insurer from considering the number of credit-seeking or promotional inquiries. It does not prohibit an insurer from considering the length of time since the most recent inquiry about a consumer's credit rating.

(4) **The law says an insurer cannot use collections identified with a medical industry code to set rates or to deny insurance. Not all credit vendors provide industry codes for collection accounts. If a vendor searches for medical references in a text field, would that action comply with the law?** Yes. Collections identified with a medical industry code cannot be used. If medical history is not coded or identified, insurers and vendors are not required to perform additional research.

(5) **The law says an insurer cannot use the initial purchase or finance of a vehicle or house that adds a new loan to the consumer's existing credit history to set rates or to deny insurance. Can my company use the number of such loans and/or the outstanding balance of such loans?**

- An insurer may not use the initial purchase of a home or vehicle to affect eligibility for insurance or insurance premiums. The initial purchase is the first loan taken out to buy a home or vehicle.

- An insurer may evaluate any subsequent borrowing by a consumer.

- A method an insurer or vendor can use to comply with the law is to eliminate vehicle and home loans from the consumer's debt load calculation.

(6) **The law says an insurer cannot use the total available line of credit to set rates or to deny insurance. Can my company use number of credit lines with limits over a set amount?**

- The law prohibits use of data related to the consumer's total available line of credit. Any attribute that evaluates the total amount of credit available to a consumer is prohibited.

- Your insurer may use the debt/credit ratio or other ratios that consider the actual debt load.

[Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010, 05-02-026 (Matter No. R 2004-01), § 284-24A-065, filed 12/29/04, effective 7/1/05. Statutory Authority: RCW 48.02.060, 48.18.100, 48.18.120, 48.19.080, 48.19.370, 48.30.010, 49.60.178, 48.18.545(7), 48.19.035(5), 02-19-013 (Matter No. R 2001-11), § 284-24A-065, filed 9/6/02, effective 10/7/02.]

Chapter 284-24B WAC

RULES THAT REQUIRE PROPERTY AND CASUALTY INSURERS TO REPORT STATISTICAL DATA

WAC

284-24B-010	Definitions that apply to this chapter.
284-24B-020	Purpose.
284-24B-030	The commissioner adopts certain statistical plans.
284-24B-040	Insurers must report statistical experience.
284-24B-050	Process for an entity to be designated a statistical agent.
284-24B-060	Statistical agents must file their statistical plans with the commissioner.
284-24B-070	Statistical agents must comply with the <i>NAIC Statistical Handbook</i> .
284-24B-080	Multiple statistical agents for the same line of insurance.
284-24B-090	Access to data.
284-24B-100	Disclosure of data.
284-24B-110	Effective date.

(2009 Ed.)

WAC 284-24B-010 Definitions that apply to this chapter. (1) **"Insurer"** means an authorized insurer that has premium, loss or loss adjustment expense data in Washington state for one or more of these lines of insurance:

(a) Property, as defined in RCW 48.11.040;

(b) Marine and transportation, as defined in RCW 48.11.050, if not exempt from statistical reporting under RCW 48.19.010 (1)(e);

(c) Vehicle, as defined in RCW 48.11.060;

(d) General casualty, as defined in RCW 48.11.070; and

(e) Surety, as defined in RCW 48.11.080.

(2) **"NAIC Statistical Handbook"** is a publication of the National Association of Insurance Commissioners (NAIC) that explains insurance statistical data and provides reporting requirements and report formats for data that statistical agents must submit to the commissioner.

(3) **"Statistical agent"** means an entity that the commissioner has designated under RCW 48.19.370(4) to collect insurance statistical data from insurers and report these data to the commissioner on behalf of those insurers.

(4) **"Statistical plan"** means a system for collecting information from insurers.

[Statutory Authority: RCW 48.02.060, 48.19.370, 06-13-035 (Matter No. R 2005-02), § 284-24B-010, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-020 Purpose. (1) The purpose of this chapter is to:

(a) Incorporate the provisions of the *NAIC Statistical Handbook* into this chapter;

(b) Prescribe the manner of reporting statistical data and the types of statistical data insurers must submit to statistical agents under RCW 48.19.370; and

(c) Establish a procedure for the commissioner to designate statistical agents under RCW 48.19.370.

(2) This chapter does not limit the powers granted to the commissioner by any law of this state.

[Statutory Authority: RCW 48.02.060, 48.19.370, 06-13-035 (Matter No. R 2005-02), § 284-24B-020, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-030 The commissioner adopts certain statistical plans. (1) By reference, the commissioner incorporates all provisions of the *NAIC Statistical Handbook* into this rule, except:

(a) Medical Professional Liability Reports: Statistical Reporting Requirements; and

(b) Medical Professional Liability Reports: Model Medical Professional Liability Statistical Plan.

(2) The commissioner will issue technical assistance advisories to notify insurers and statistical agents of the effective date of any future revisions to the *NAIC Statistical Handbook*.

[Statutory Authority: RCW 48.02.060, 48.19.370, 06-13-035 (Matter No. R 2005-02), § 284-24B-030, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-040 Insurers must report statistical experience. (1) Under RCW 48.19.370(4), the commissioner may designate certain rating organizations or other entities as statistical agents to gather, compile, and report insurance statistical data.

(2) RCW 48.19.370 says each insurer must report loss and expense experience to the commissioner. As a condition

of transacting the business of insurance under RCW 48.05.040, each insurer must:

(a) Report its insurance statistical data to a statistical agent designated by the commissioner in accordance with the statistical plans filed with the commissioner by the statistical agent under WAC 284-24B-060;

(b) Comply with the reporting requirements and data quality procedures in the *NAIC Statistical Handbook*; and

(c) Adopt edit and audit procedures to screen and check data for reasonableness and accuracy.

(3) So the commissioner may assure compliance with this chapter, each insurer filing rates under chapter 48.19 RCW must include the name of its statistical agent for that line of insurance.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-040, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-050 Process for an entity to be designated a statistical agent. The commissioner may designate an entity as a statistical agent if the entity makes a written request to the commissioner that:

(1) Identifies the line(s) of business for which the entity will collect and report statistical experience;

(2) States the entity's qualifications to act as a statistical agent; and

(3) Agrees to:

(a) Comply with the reporting requirements and data quality procedures in the *NAIC Statistical Handbook*, and all rules, technical advisories and directives issued by the commissioner;

(b) Report statistical data to the commissioner in a timely manner; and

(c) Submit to an examination in accordance with procedures described in RCW 48.03.010.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-050, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-060 Statistical agents must file their statistical plans with the commissioner. Entities that are designated as statistical agents under WAC 284-24B-050 must promptly file with the commissioner:

(1) Their statistical plans, including standard report formats; and

(2) All changes in their statistical plans or reporting formats.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-060, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-070 Statistical agents must comply with the *NAIC Statistical Handbook*. Statistical agents must collect statistical data in a form and detail as required by the *NAIC Statistical Handbook* and any additional detail required by rules adopted by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-070, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-080 Multiple statistical agents for the same line of insurance. If the commissioner designates more than one statistical agent to collect statistical data for a particular line of insurance, those statistical agents must arrange to

file reports that combine all data collected by the statistical agents for that line(s) of insurance. The statistical agents may arrange among themselves for the equitable sharing of the costs to produce combined reports.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-080, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-090 Access to data. The commissioner shall have access to all statistical data that statistical agents collect to comply with this chapter. If requested by the commissioner, statistical agents must promptly provide a copy of any report produced from data that the statistical agent is required to collect under this chapter.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-090, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-100 Disclosure of data. (1) Aggregate data reported to the commissioner by statistical agents are available for public inspection.

(2) If data submitted to the commissioner by a statistical agent appear likely to identify individual insurers, claimants or insureds, or the statistical agent or an insurer asserts that data are exempt from public disclosure under RCW 48.02.-120(3), such data may not be publicly disclosed until the commissioner:

(a) Notifies the statistical agent and any insurer that has asserted the data to be exempt from public disclosure of the disclosure request;

(b) Provides a thirty-day period from the date of notice for any insurer that reported data to the statistical agent to assert that its data are trade secrets or are otherwise protected from disclosure; and

(c) Provides aggrieved insurers with the opportunity to request a hearing under RCW 48.04.010 and chapter 34.05 RCW.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-100, filed 6/15/06, effective 7/16/06.]

WAC 284-24B-110 Effective date. Insurers must affiliate with a designated statistical agent by January 1, 2007, and report data in accordance with the requirements included in the *NAIC Statistical Handbook* and the designated statistical agent's filed statistical plan.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24B-110, filed 6/15/06, effective 7/16/06.]

Chapter 284-24C WAC

SPECIFIC RULES THAT APPLY TO STATISTICAL PLANS FOR MEDICAL PROFESSIONAL LIABILITY REPORTS

WAC

284-24C-010	Definitions that apply to these rules.
284-24C-020	Purpose.
284-24C-030	Statistical reporting for medical professional liability insurance.
284-24C-040	<i>NAIC Statistical Handbook</i> —Medical professional liability statistical plan reporting requirements.
284-24C-050	Additional medical professional liability statistical plan reporting requirements required by the commissioner.
284-24C-060	Effective dates.

WAC 284-24C-010 Definitions that apply to these rules. (1) **"Medical malpractice insurer"** means an authorized general casualty insurer that has premium, loss or loss adjustment expense data for medical malpractice insurance.

(2) **"Medical professional liability insurance"** or **"medical malpractice insurance"** provides coverage for tort claims brought against various medical-related institutions and medical professionals, such as:

(a) Institutions, including hospitals, infirmaries, nursing homes, mental institutions, blood banks, sanitariums, and clinics; and

(b) Individual medical professionals including physicians, surgeons, dentists, nurses, pharmacists, opticians, optometrists, physiotherapists, chiropractors, laboratory technicians, and various specialists.

(3) **"Medical malpractice statistical agent"** means an organization designated by the commissioner under RCW 48.19.370(4) to gather, compile and report medical malpractice statistical data.

(4) **"NAIC Statistical Handbook"** is a publication of the National Association of Insurance Commissioners (NAIC) that explains insurance statistical data and provides reporting requirements and report formats for data that statistical agents must submit to the commissioner.

(5) **"Statistical plan"** means a system for collecting information from insurers.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-010, filed 6/15/06, effective 7/16/06.]

WAC 284-24C-020 Purpose. (1) The purpose of this chapter is to:

(a) Incorporate the provisions of chapter 284-24B WAC into this chapter;

(b) Prescribe the manner of reporting statistical data and the types of statistical data medical malpractice insurers must submit to statistical agents under RCW 48.19.370; and

(c) Establish a medical professional liability statistical plan.

(2) This chapter does not limit the powers granted to the commissioner by any law of this state.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-020, filed 6/15/06, effective 7/16/06.]

WAC 284-24C-030 Statistical reporting for medical professional liability insurance. Each medical malpractice insurer must:

(1) Comply with the provisions of RCW 48.19.370 and chapter 284-24B WAC; and

(2) Report its insurance statistical data to a statistical agent designated by the commissioner in accordance with the statistical plans filed by the statistical agent under WAC 284-24B-060 and all additional detail required by this chapter.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-030, filed 6/15/06, effective 7/16/06.]

WAC 284-24C-040 NAIC Statistical Handbook—Medical professional liability statistical plan reporting requirements. These data items, as specified by the *NAIC Statistical Handbook*, must be reported by each medical malpractice insurer to a medical malpractice statistical agent:

(2009 Ed.)

(1) Company number: Experience must be reported by the company number assigned by the medical malpractice statistical agent. Medical malpractice statistical agents must convert each company number to NAIC group and company code numbers.

(2) Accounting/calendar date:

(a) Accounting quarter (where applicable).

(b) Accounting year.

(3) Transaction identifier and amounts. Identify the following items and their respective amounts:

(a) Written premium.

(b) Paid losses.

(c) Paid allocated loss adjustment expenses.

(d) Outstanding losses.

(e) Outstanding allocated loss adjustment expense.

(4) Subline identifier:

(a) Hospital professional and other health care facilities liability.

(b) Physicians, surgeons, and dentists professional liability.

(c) Other health care professional liability.

(d) All composite rated risks.

(e) Indivisible premium policy experience.

(5) Classification codes. Individual industry classification codes describing specific coverage. In Washington, the current Insurance Services Office (ISO) five digit common statistical base classifications must be used.

(6) State indicator.

(7) Policy effective year:

(a) The effective date of the policy, defined as the beginning date of the declarations page or renewal certificate.

(b) For claims-made tail coverage, the date on which tail coverage began is required.

(8) Type of program indicator:

(a) Monoline; or

(b) Package.

(9) Date of entry into the claims-made program:

(a) The date of entry into the claims-made program is the retroactive date employed in claims-made coverage in order to exclude coverage for occurrences that took place prior to that date even though claims resulting from such occurrences are made within the policy period.

(b) Claims-made tail coverage records must include, in the date of entry into the claims-made program field, the date applicable to the basic and excess coverage.

(10) Type of policy contract identifier:

(a) Claims-made coverage - basic and excess.

(b) Claims-made coverage - tail.

(c) Occurrence coverage.

(11) Exposures. The applicable exposure is required for each of the subdivisions of experience for which separate classification codes and exposure bases exist. The current Insurance Services Office (ISO) exposure reporting basis included with the common statistical base classifications must be used.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-040, filed 6/15/06, effective 7/16/06.]

WAC 284-24C-050 Additional medical professional liability statistical plan reporting requirements required by the commissioner. In addition to the data items specified

by the *NAIC Statistical Handbook*, these data items, specific to this medical malpractice statistical plan rule, must be reported by each medical malpractice insurer to a medical malpractice statistical agent:

- (1) Claim dates:
 - (a) Incident month/year; and
 - (b) Report month/year.
 - (c) Closed month/year (closed claims only).
- (2) Additional transaction identifiers and details. Identify the following items and their respective amounts:
 - (a) Paid losses segmented by amounts paid or incurred for past and future:
 - (i) Wage loss;
 - (ii) Medical expenses; and
 - (iii) All other losses.
 - (b) Paid allocated loss adjustment expenses segmented by amounts paid for:
 - (i) Defense counsel;
 - (ii) Expert witness; and
 - (iii) All other allocated loss adjustment expenses.
 - (c) Outstanding losses segmented by amounts paid or incurred for past and future:
 - (i) Wage loss;
 - (ii) Medical expenses; and
 - (iii) All other losses.
 - (d) Outstanding allocated loss adjustment expense segmented by amounts paid or incurred for:
 - (i) Defense counsel;
 - (ii) Expert witness; and
 - (iii) All other allocated loss adjustment expenses.
- (3) Policy limit per incident.
- (4) Deductible or retention.
- (5) Medical outcome classifications (use only one code):
 - (a) Emotional only: Fright, no physical damage.
 - (b) Temporary: Slight - lacerations, contusions, minor scars, rash. No delay.
 - (c) Temporary: Minor - infections, mis-set fracture, fall in hospital. Recovery delayed.
 - (d) Temporary: Major - burns, surgical material left, drug side effect, brain damage. Recovery delayed.
 - (e) Permanent: Minor - loss of fingers, loss or damage to organs. Includes nondisabling injuries.
 - (f) Permanent: Significant - deafness, loss of limb, loss of eye, loss of one kidney or lung.
 - (g) Permanent: Major - paraplegia, blindness, loss of two limbs, brain damage.
 - (h) Permanent: Grave - quadriplegia, severe brain damage, lifelong care or fatal prognosis.
 - (i) Permanent: Death.
- (6) Act or omission classification, as follows:
 - (a) Diagnosis related;
 - (b) Anesthesia related;
 - (c) Surgery related;
 - (d) Medication related;
 - (e) Intravenous and/or blood products related;
 - (f) Obstetrics related;
 - (g) Treatment related;
 - (h) Monitoring related;
 - (i) Biomedical equipment and/or product related;
 - (j) Behavioral health related; or
 - (k) All other.

(7) Territory indicator for the county of the principal location in which the incident of alleged medical malpractice occurred.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-050, filed 6/15/06, effective 7/16/06.]

WAC 284-24C-060 Effective dates. (1) Medical malpractice insurers must:

(a) Comply with chapter 284-24B WAC, affiliate with a designated medical malpractice statistical agent by January 1, 2007, and promptly begin reporting data required under WAC 284-24C-040; and

(b) Begin reporting statistical data specified under WAC 284-24C-050 for claims opened on or after January 1, 2007, to a designated medical malpractice statistical agent in calendar year 2009 in accordance with the medical malpractice statistical agent's filed statistical plan.

(2) Medical malpractice statistical agents must begin reporting statistical data under these rules to the commissioner by September 30, 2009.

[Statutory Authority: RCW 48.02.060, 48.19.370. 06-13-035 (Matter No. R 2005-02), § 284-24C-060, filed 6/15/06, effective 7/16/06.]

Chapter 284-24D WAC

MEDICAL MALPRACTICE CLOSED CLAIM DATA REPORTING RULES FOR FACILITIES AND PROVIDERS

WAC

284-24D-010	Purpose.
284-24D-020	Definitions.
284-24D-030	How will the commissioner ensure data confidentiality under RCW 48.140.060(2)?
284-24D-040	How are closed claims reported to the commissioner?
284-24D-050	How will the OIC assign user ID codes to reporting entities?
284-24D-060	What types of claims must be reported to the commissioner?
284-24D-070	Are write-offs or other small sums of money provided as customer service gestures considered claims?
284-24D-080	When is a claim considered closed?
284-24D-090	When are closed claim reports due?
284-24D-100	Can a reporting entity reopen a claim or make changes to previously reported data?
284-24D-110	How should reporting entities assign claim and incident identifiers?
284-24D-120	When is the primary insuring entity responsible for reporting closed claims to the commissioner?
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284-24D-350	How are economic damages allocated under RCW 48.140.030 (10)(b)(iii)?
284-24D-360	What elements of economic loss must a reporting entity include when reporting economic damages?
284-24D-362	What process must a person use to estimate economic damages?
284-24D-364	What sources of information can a reporting entity use to estimate economic damages?
284-24D-366	Will the OIC provide guidelines or tools which reporting entities can use when estimating economic damages?
284-24D-370	How are paid and estimated economic damages reported under RCW 48.140.040 (10)(b)(iii)?

WAC 284-24D-010 Purpose. This chapter contains procedural rules to implement chapter 48.140 RCW. This chapter describes the rules, practices and procedures that insuring entities, self-insurers, health care facilities and providers must use to report data to the commissioner as required by chapter 48.140 RCW.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-010, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Allocated loss adjustment expense" or "ALAE" means defense and cost containment expenses paid or incurred for defense, litigation and medical cost containment expenses and services. Either internal staff, such as in-house counsel or professional medical staff, or external staff, such as defense counsel or expert witnesses, may provide defense and cost containment services.

(a) Defense and cost containment expenses and services include:

(i) Defense services provided by:

(A) Attorneys or expert witnesses; and

(B) Private investigators, hearing representatives or fraud investigators.

(ii) Cost containment activities and services performed by external or internal experts to defend the claim, including:

(A) Case evaluation, such as evaluating whether the medical care provided met professional standards;

(B) Risk assessment;

(C) Case preparation and management;

(D) Medical record review; and

(E) Settlement negotiations.

(iii) Specific case-related expenses, such as:

(A) Surveillance expenses;

(B) Court costs;

(C) Medical examination fees;

(D) The costs of laboratory, X-ray and other medical tests;

(E) Autopsy expenses;

(F) Stenographic expenses;

(G) Fees associated with witnesses and summonses; and

(H) The costs to obtain copies of documents.

(b) Allocated loss adjustment expenses do not include:

(i) Expenses incurred to determine whether coverage is available; or

(ii) Expenses or costs associated with external or internal claims adjusting staff.

(2) "Claim" means the same as in RCW 48.140.010(1).

(3) "Claim identifier" means the unique number assigned to a claim by the reporting entity as required by RCW 48.140.030 (1)(a).

(4) "Claimant" means the same as in RCW 48.140.010 (2).

(5) "Closed claim" means the same as in RCW 48.140.-010(3).

(6) "Commissioner" means the insurance commissioner.

(7) "Companion claims" means the same as in RCW 48.140.030 (1)(b).

(8) "Economic damages" means the same as in RCW 4.56.250 (1)(a).

(9) "Excess insuring entity" means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.

(10) "Facility" means the same as in RCW 48.140.010 (6).

(11) "Paid and estimated economic damages" means economic damages paid to a claimant based on:

(a) Objectively verifiable evidence; and

(b) Estimates developed from the injured person's available personal data and related economic data. Estimated economic damages typically include, but are not limited to:

(i) Lost earnings and benefits;

(ii) Lost earnings potential;

(iii) Lost value of household services; and

(iv) Future medical care costs.

(12) "Incident identifier" means the unique number assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of actual or alleged medical malpractice.

(13) "Insuring entity" means the same as in RCW 48.140.010(8).

(14) "Medical malpractice" means the same as in RCW 48.140.010(9).

(15) "OIC" means office of insurance commissioner.

(16) "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage.

(17) "Provider" means the same as in RCW 48.140.010 (7).

(18) "Record identifier" means a number assigned to a claim by the reporting site when a reporting entity first enters closed claim data.

(19) "Reporting entity" means any person or entity required to report data under RCW 48.140.020.

(20) "Reporting site" means the OIC web-based application that insuring entities, facilities, providers, and self-insurers must use to report medical malpractice closed claim data.

(21) "Self-insurer" means the same as in RCW 48.140.-010(11).

(22) "User ID" is a permanent number assigned by the reporting site to each insuring entity, self-insurer, facility or provider.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-020, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under chapter 48.140 RCW from public disclosure. To ensure data confidentiality, the commissioner will:

- (1) Develop a secure web-based data reporting application;
- (2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;
- (3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;
- (4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;
- (5) Develop procedures to use if data are accidentally released; and
- (6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-030, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-040 How are closed claims reported to the commissioner? (1) Except as provided in subsection (2) of this section, reporting entities must use the reporting site maintained by the OIC to report closed claims. To help reporting entities collect data, the commissioner will post reporting forms on the OIC internet site so that reporting entities can organize data before entering data into the reporting site.

(2) The commissioner may permit a reporting entity to transmit data electronically in an alternative format if the reporting entity develops, at its own expense, an interface that is compatible with the OIC closed claim data base.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-040, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-050 How will the OIC assign user ID codes to reporting entities? The reporting site will assign a permanent user ID to each reporting entity the first time it enters a closed claim into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-050, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-060 What types of claims must be reported to the commissioner? The types of closed medical malpractice claims that must be reported to the OIC include:

- (1) Claims closed with an indemnity payment;
- (2) Claims closed with paid allocated loss adjustment expenses; and
- (3) Claims closed with both indemnity payments and allocated loss adjustment expenses.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-060, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider

waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Reporting entities are not required to report these types of accommodations to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-070, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-080 When is a claim considered closed? A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

- (1) Issues the final payment to the claimant in the form of a check or draft;
- (2) Pays all outstanding bills for allocated loss adjustment expenses; and
- (3) If applicable, receives all indemnity and allocated loss adjustment expense claim payment data needed for reporting under this chapter from a facility, provider or excess insuring entity.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-080, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-090 When are closed claim reports due? Under RCW 48.140.020, reporting entities must report all claims closed in the preceding calendar year to the commissioner.

(1) Beginning in 2009, closed claim reports for the prior calendar year are due by March 1.

(2) A reporting entity may report a closed claim any time after the claim is closed, but no later than March 1.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-090, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-100 Can a reporting entity reopen a claim or make changes to previously reported data? The reporting site will allow the reporting entity to change previously reported closed claim data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow a reporting entity to change previously reported data.

(a) The reporting entity can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

(b) Changes and corrections submitted by reporting entities after June 30 of each year will appear in future reports and statistical summaries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-100, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-110 How should reporting entities assign claim and incident identifiers? (1) Consistent with requirements of RCW 48.140.030(1), the reporting entity

must assign a different claim identification number to each closed claim report.

(a) The claim identifier must consist solely of numbers. When the reporting entity enters a claim into the reporting site, the site will automatically combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(b) The OIC will use the record identifier to trace the claim for auditing purposes.

(2) If a claimant makes claims against more than one facility or provider, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

(a) The incident identifier for companion claims must consist solely of numbers.

(b) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-110, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-120 When is the primary insuring entity responsible for reporting closed claims to the commissioner? Primary insuring entities are principally responsible for reporting closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any claim payments or ALAE payments made by:

- (a) A facility or provider;
- (b) An excess insuring entity; or
- (c) Any other person or entity on behalf of the provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

- (a) The primary insuring entity must report all paid indemnity and allocated loss adjustment expense; and
- (b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-120, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-130 When is an excess insuring entity responsible for reporting closed claims to the commissioner? (1) If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs allocated loss adjustment expenses, the excess insuring entity is principally responsible to report closed claim data required under chapter 48.140 RCW and this chapter.

(a) Self-insurers must report all claim payments and allocated loss adjustment expenses to the excess insuring entity for reporting purposes; and

(b) The excess insuring entity must report data on behalf of itself and the self-insurer.

(2) An excess insurer is not responsible to report closed claim data reported by a primary insuring entity under WAC 284-24D-120.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-130, filed 6/4/07, effective 7/22/07.]

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WAC 284-24D-140 When is a self-insurer responsible for reporting closed claims to the commissioner? If a closed claim payment falls within its self-insured retention, the self-insurer must report closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-140, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-150 May a self-insurer report claims on behalf of itself and an excess insuring entity? A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insurer. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report closed claim data required under chapter 48.140 RCW and this chapter on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with RCW 48.140.020(2).

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-150, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-160 When is a facility or provider principally responsible for reporting closed medical malpractice claims to the commissioner? Under RCW 48.140.-020(1), a facility or provider must report closed claims if the facility or provider:

(1)(a) Makes indemnity payments directly to the claimant or incurs ALAE expenses to defend the claim, or both; and

(b) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay for the claim; or

(2) Is insured by a risk retention group and the risk retention group refuses to report closed claim data and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. 3901 net seq.) preempts state law; or

(3) Is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claim data and asserts a federal exemption or other jurisdictional preemption.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-160, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-170 What does "date of notice" mean? RCW 48.140.030 (8)(b) says that reporting entities must report the date that the insuring entity, self-insurer, facility or provider is presented with the claim. For reporting purposes, the "date of notice" is the date on which the:

(1) Insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

(2) Claimant notifies the facility or provider of a claim if insurance coverage is not available.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-170, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-180 How should the type of medical specialty be reported? When reporting medical specialties as required under RCW 48.140.030(2), reporting entities

must use the *Specialty Codes* published by the National Practitioner Data Bank (NPDB).

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-180, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-190 How should the type of health care facility be reported? When reporting the type of health care facility under RCW 48.140.030(3), the reporting entity must use the *Type of Organization Codes* published by the NPDB. Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-190, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-200 What should be reported as the primary location where the medical malpractice incident occurred? When reporting the location within a facility where the incident occurred under RCW 48.140.030(4), the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

- (1) Catheterization lab;
- (2) Critical care unit;
- (3) Dispensary;
- (4) Emergency department;
- (5) Labor and delivery room;
- (6) Laboratory;
- (7) Nursery;
- (8) Operating room;
- (9) Outpatient department;
- (10) Patient room;
- (11) Pharmacy;
- (12) Physical therapy department;
- (13) Radiation therapy department;
- (14) Radiology department;
- (15) Recovery room;
- (16) Rehabilitation center;
- (17) Special procedure room;
- (18) Location other than an inpatient facility:
 - (a) Clinical support center, such a laboratory or radiology center;
 - (b) Office;
 - (c) Walk-in clinic; or
 - (d) Other;
 - (19) Other department in hospital;
 - (20) Unknown; and
 - (21) Other.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-200, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-210 How should the incident city be reported? When reporting the incident city under RCW 48.140.030(5), the reporting entity must report the incident city based on the location of the facility where the incident occurred. If more than one incident led to the claim, the reporting entity must choose the location where the incident occurred that most directly caused the injury.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-210, filed 6/4/07, effective 7/22/07.]

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WAC 284-24D-220 How should injury severity be reported using the National Practitioner Data Bank (NPDB) severity scale? When reporting the severity of an injury under RCW 48.140.030(7), the reporting entity must report using the NPDB severity scale. This scale shows the medical outcome for temporary and permanent injuries, and is included below.

- (1) Temporary injuries include:
 - (a) Emotional injury only, such as fright, where no physical damage occurred;
 - (b) Insignificant injury such as lacerations, contusions, minor scars or rash where no delay in recovery occurs;
 - (c) Minor injury such as infection, fracture set improperly, or a fall in the hospital, where recovery is complete but delayed; or
 - (d) Major injury such as burns, surgical material left, drug side effect, brain damage, where recovery is complete but delayed.
- (2) Permanent injuries include:
 - (a) Minor injury such as loss of fingers, loss or damage to organs, where the injury is not disabling;
 - (b) Significant injury such as deafness, loss of limb, loss of eye, loss of one kidney or lung;
 - (c) Major injury such as paraplegia, blindness, loss of two limbs, brain damage;
 - (d) Grave injury such as quadriplegia, severe brain damage, life long care or fatal prognosis; or
 - (e) Death.
- (3) The reporting entity should report the principal injury if several injuries are involved.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-220, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-230 What should be reported as the reason for the medical malpractice claim? When reporting the reason for a medical malpractice claim under RCW 48.140.030(11), the reporting entity must use the same *Allegation Group and Specific Allegation Codes* published by the National Practitioner Data Bank.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-230, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-240 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 48.140.030(9), reporting entities must describe the method of claim disposition using one of the descriptions listed below:

- (1) Claim abandoned by claimant.
- (2) Claim settled by the parties.
- (3) Claim is disposed of by a court when the court issues a:
 - (a) Directed verdict for plaintiff;
 - (b) Directed verdict for defendant;
 - (c) Judgment notwithstanding verdict for plaintiff (judgment for defendant);
 - (d) Judgment notwithstanding verdict for defendant (judgment for plaintiff);
 - (e) Involuntary dismissal;
 - (f) Judgment for plaintiff;
 - (g) Judgment for defendant;
 - (h) Judgment for plaintiff after appeal; or

- (i) Judgment for defendant after appeal.
- (4) Claim settled by alternative dispute resolution process, whether resolved by:
 - (a) Arbitration award for plaintiff;
 - (b) Arbitration for defense;
 - (c) Mediation;
 - (d) Private trial; or
 - (e) Other type of alternative dispute resolution process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-240, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-250 How should information about the timing of the settlement be reported? When reporting the timing of the settlement under RCW 48.140.030(9), reporting entities must report whether the claim is settled:

- (1) Before filing suit, requesting arbitration or mediation hearing;
- (2) Before trial, arbitration or mediation;
- (3) During trial, arbitration or mediation;
- (4) After trial or hearing, but before judgment or award;
- (5) After judgment or decision, but before appeal;
- (6) During an appeal; or
- (7) After an appeal.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-250, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-260 Are claim payments reported on a gross or net basis? Reporting entities must report claim payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:

- (1) Reimbursement for a deductible by the insured;
- (2) Reimbursement for claim payments by a reinsurer; or
- (3) Anticipated subrogation recoveries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-260, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-270 What does an insuring entity report when the damages exceed policy limits? When damages exceed the policy limits, the insuring entity must report the total amount it paid on behalf of its insured. The reporting entity must report:

- (1) The actual claim payment, which may be either:
 - (a) The policy limit; or
 - (b) The actual amount paid on behalf of the insured. The actual amount paid by the insuring entity may be either higher or lower than the policy limit, depending on the settlement agreement.
- (2) Additional payments made to the claimant by an insured facility or provider; and
- (3) Allocated loss adjustment expenses paid by both the insuring entity and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-270, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-280 Are subrogation recoveries subject to reporting? Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subro-

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gation proceeds and any ALAE incurred to obtain those proceeds. If necessary, the insuring entity may reopen the claim under WAC 284-24D-100.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-280, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-290 How are structured settlements reported? (1) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.

(2) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-290, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-300 If the court itemizes damages, what information must be reported? If the court itemizes damages, the reporting entity must report these itemized damages:

- (1) The total amount of the verdict, judgment, or settlement;
- (2) The gross amount paid to indemnify the claimant;
- (3) Itemized economic and noneconomic damages as allocated by the court; and
- (4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-300, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-310 What information must be reported if the court does not itemize damages or a claim is settled by the parties? When reporting claims under RCW 48.140.030 (10)(b), the reporting entity must report losses on a gross basis, including:

- (1) The total amount of the verdict, judgment, or settlement;
- (2) The gross amount paid to indemnify the claimant;
- (3) Paid and estimated economic damages; and
- (4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-310, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-320 How should "companion claims" be reported? If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claims in this manner:

- (1) If a claimant makes a claim against more than one facility or provider, the reporting entity must assign the same incident identifier to each "companion claim."
- (2) The reporting entity must maintain all data required under chapter 48.140 RCW and this chapter for each facility or provider it defends.

(3) Indemnity payments and allocated loss adjustment expenses paid to defend and settle each claim must be reported separately for each facility or provider. The reporting entity must allocate:

- (a) Indemnity payments between defendants based on an assessment of comparative fault; and

(b) ALAE payments between defendants based on which defendant benefited from the defense services.

(4) If the reporting entity makes payments in the absence of clear legal liability, it may allocate claim or ALAE payments equally among all defendants.

(5) Under this section, the reporting entity is responsible for reporting incident level data only for its own claims.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-320, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-330 How much detail is required when reporting allocated loss adjustment expenses? When reporting allocated loss adjustment expenses under RCW 48.140.030 (10)(a)(v) or (b)(iv), the reporting entity must report:

- (1) ALAE for defense counsel, including both in-house and outside counsel;
- (2) ALAE for expert witnesses, including both in-house and outside experts;
- (3) All other ALAE; and
- (4) Total ALAE.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-330, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-340 If defense services are provided by company employees, must company overhead be reported with ALAE? (1) Some insuring entities and self-insurers use the services of internal staff to defend claims. For example, an insuring entity or self-insurer may:

- (a) Ask its professional medical staff to:
 - (i) Evaluate medical care;
 - (ii) Review medical records; or
 - (iii) Assist in case preparation.
- (b) Retain in-house legal counsel to:
 - (i) Assess risk of litigation;
 - (ii) Evaluate legal issues;
 - (iii) Engage in case preparation or management activities, or settlement negotiations.
- (2) When calculating ALAE, a reporting entity that uses internal staff to defend a claim as described in subsection (1) of this section and WAC 284-24D-020(1):

- (a) Must include salary, benefits and an allocation for overhead for those employees; and
- (b) May use average salaries and time studies when calculating ALAE.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-340, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-350 How are economic damages allocated under RCW 48.140.030 (10)(b)(iii)? If the reporting entity makes indemnity payments to a claimant, the reporting entity must allocate economic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not allocate using a fixed formula, such as fifty percent of total paid indemnity, to economic damages.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-350, filed 6/4/07, effective 7/22/07.]

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WAC 284-24D-360 What elements of economic loss must a reporting entity include when reporting economic damages? When reporting paid and estimated economic damages, reporting entities must use reasonable judgment to estimate the following elements of loss:

- (1) Medical expenses;
- (2) Loss of earnings;
- (3) Burial costs;
- (4) Cost of obtaining substitute domestic services;
- (5) Loss of employment; and
- (6) Loss of business or employment opportunities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-360, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-362 What process must a person use to estimate economic damages? If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the person calculating damages must use the principles listed in this section.

- (1) Where appropriate, the person estimating economic damages must:
 - (a) Project the elements of loss listed in WAC 284-24D-360:
 - (i) For the duration of the injury or disability; or
 - (ii) In the event of death, for the anticipated life span of the injured person; and
 - (b) Discount damages to present value;
 - (c) Consider related factors, such as:
 - (i) Issues of negligence and liability;
 - (ii) The relative strength of the defense; and
 - (iii) The component of the claim payment driven by economic damages.
- (2) Reporting entities must select reasonable discount factors when estimating economic damages.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-362, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-364 What sources of information can a reporting entity use to estimate economic damages? When estimating economic damages, the person estimating damages may use data from public sources, such as the Bureau of Labor Statistics, to supplement data collected during the claim investigation.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-364, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-366 Will the OIC provide guidelines or tools which reporting entities can use when estimating economic damages? From time to time, the OIC may publish information or suggestions that reporting entities can use when estimating economic damages. Periodically, the OIC will update its internet site to include links to documents or information of interest to reporting entities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-366, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-370 How are paid and estimated economic damages reported under RCW 48.140.040 (10)(b)(iii)? A reporting entity must:

- (1) Combine all elements of paid and estimated economic loss described in WAC 284-24D-360; and

(2) Report one figure for paid and estimated economic loss to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-370, filed 6/4/07, effective 7/22/07.]

Chapter 284-24E WAC

MEDICAL MALPRACTICE CLAIM SETTLEMENT DATA REPORTING RULES FOR ATTORNEYS AND CLAIMANTS

WAC

284-24E-010	Purpose.
284-24E-020	Definitions.
284-24E-030	How will the commissioner ensure data confidentiality under RCW 48.140.060(2)?
284-24E-040	How is claim settlement data reported to the commissioner?
284-24E-050	How will the OIC assign user ID codes?
284-24E-060	What types of settled claims must be reported to the commissioner?
284-24E-063	When is a claim considered settled and subject to reporting with the OIC?
284-24E-070	Are write-offs or other small sums of money provided as customer service gestures considered claims?
284-24E-080	Who has the primary responsibility for reporting claim settlement data to the commissioner?
284-24E-090	When are claim reports due?
284-24E-100	Can settlement reports be reopened to make changes or corrections to previously reported data?
284-24E-110	How should claim disposition information be reported?
284-24E-120	How should information about the timing of the settlement be reported?
284-24E-130	How is the judgment or settlement amount reported?
284-24E-140	How are structured settlements reported?
284-24E-150	How should claims settlement data be reported if there is more than one defendant?

WAC 284-24E-010 Purpose. This chapter contains procedural rules to implement RCW 7.70.140. This chapter describes the rules, practices and procedures that claimants and their attorneys must use to report claim settlement data to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-010, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-020 Definitions. The definitions in this section apply throughout this chapter.

- (1) "Claim" means the same as in RCW 48.140.010(1).
- (2) "Claimant" means the same as in RCW 48.140.010(2), and, for reporting purposes, includes a claimant's legal representative.
- (3) "Commissioner" means the insurance commissioner.
- (4) "Facility" means the same as in RCW 48.140.010(6).
- (5) "Insuring entity" means the same as in RCW 48.140.010(8).
- (6) "Medical malpractice" means the same as in RCW 48.140.010(9).
- (7) "OIC" means office of insurance commissioner.
- (8) "Provider" means the same as in RCW 48.140.010(7).
- (9) "Record identifier" means the number assigned to a claim by the reporting site when a person first enters claim settlement information.
- (10) "Reporting site" means the OIC web-based application that attorneys and claimants must use to report medical malpractice claim settlement data.

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(11) "Self-insurer" means the same as in RCW 48.140.010(11).

(12) "User ID" is a permanent number assigned by the reporting site to any claimant or attorney who reports claim settlement data.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-020, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under RCW 7.70.140 from public disclosure. To ensure data confidentiality, the commissioner will:

- (1) Develop a secure web-based data reporting application;
- (2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;
- (3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;
- (4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;
- (5) Develop procedures to use if data are accidentally released; and
- (6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-030, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-040 How is claim settlement data reported to the commissioner? Persons reporting claim settlement data must use the reporting site maintained by the commissioner. To help attorneys and claimants collect data, the commissioner will post a reporting form on the OIC internet site so that claim settlement data can be organized before it is entered into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-040, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-050 How will the OIC assign user ID codes? The reporting site will assign a permanent user ID to an attorney or claimant the first time the attorney or claimant enters claim settlement data into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-050, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-060 What types of settled claims must be reported to the commissioner? If a medical malpractice claim is actionable under chapter 7.70 RCW and the claimant receives an indemnity payment from an insuring entity, self-insurer, facility or provider, the claimant or his or her attorney must report claim settlement data to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-060, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-063 When is a claim considered settled and subject to reporting with the OIC? A claim is settled when the claimant:

- (1) Receives final indemnity payment(s) from all defendants;
- (2) Pays all related legal expenses; and
- (3) Pays all related attorney fees agreed to by the claimant and his or her attorney.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-063, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Claimants are not required to report these types of accommodations to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-070, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-080 Who has the primary responsibility for reporting claim settlement data to the commissioner? (1) If a claimant is represented by an attorney, the attorney must report claim settlement data to the commissioner after the claim is settled.

- (2) If a claimant is not represented by an attorney:

(a) The claimant must report claim settlement data to the commissioner; and

(b) An insuring entity, self-insurer or provider may assist or inform the claimant of his or her reporting responsibilities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-080, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-090 When are claim reports due? Under RCW 7.70.140, a claimant or his or her attorney must report claims settled in the preceding calendar year to the commissioner.

(1) Beginning in 2009, claim settlement reports for the prior calendar year are due by March 1.

(2) An attorney or claimant may enter data into the reporting site at any time after the claim is settled, but no later than March 1.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-090, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-100 Can settlement reports be reopened to make changes or corrections to previously reported data? The reporting site will allow an attorney or claimant to change previously reported claim settlement data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries can be prepared as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow an attorney or claimant to change previously reported data.

(a) An attorney or claimant can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

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(b) Changes and corrections submitted after June 30 of each year will appear in future reports and statistical summaries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-100, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-110 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 7.70.140 (2)(b)(v), an attorney or claimant must describe the method of claim disposition using one of the descriptions listed below:

- (1) Claim is settled by the parties.
- (2) Claim is disposed of by a court when the court issues

a:

- (a) Directed verdict for plaintiff;
- (b) Judgment notwithstanding verdict for defendant (judgment for plaintiff);
- (c) Judgment for plaintiff; or
- (d) Judgment for plaintiff after appeal.
- (3) Claim settled by alternative dispute resolution process, whether resolved by:

- (a) Arbitration;
- (b) Mediation;
- (c) Private trial; or
- (d) Other type of alternative dispute resolution process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-110, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-120 How should information about the timing of the settlement be reported? Persons reporting claims must report whether the claim is settled:

- (1) Before trial, arbitration or mediation;
- (2) During trial, arbitration or mediation;
- (3) After trial or hearing, but before judgment or award;
- (4) After judgment or decision, but before appeal;
- (5) During an appeal; or
- (6) After an appeal.

[Statutory Authority: RCW 48.02.060 and 48.140.060.08-03-128 (Matter No. R 2007-12), § 284-24E-120, filed 1/23/08, effective 2/23/08. Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-120, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-130 How is the judgment or settlement amount reported? Persons reporting claims must report the total amount paid by all defendants to the claimant to settle the claim.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-130, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-140 How are structured settlements reported? (1) If a claim is settled with a structured settlement agreement, the attorney or claimant must report the lump-sum payment that is paid for the annuity.

(2) If a claim is settled with a combination of a lump-sum payment to the claimant and a structured settlement, the attorney or claimant must report the sum of both payments.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-140, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-150 How should claims settlement data be reported if there is more than one defendant? An

attorney or claimant must wait until all claims are settled before reporting under RCW 7.70.140. After all claims are settled, the person reporting claim settlement data must report these data to the commissioner:

- (1) The total of all settlements paid by all defendants; and
- (2) The total amounts paid by the claimant for legal expenses, itemized by:
 - (a) Court costs;
 - (b) Expert witnesses fees; and
 - (c) Attorney fees and expenses.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-150, filed 6/4/07, effective 7/22/07.]

Chapter 284-26 WAC

INSIDER TRADING OF EQUITY SECURITIES OF A DOMESTIC STOCK INSURANCE COMPANY

WAC

284-26-010	Definition of certain terms.
284-26-020	Transactions exempted from the operation of RCW 48.08.120.
284-26-030	Filing of statements.
284-26-040	Ownership of more than ten percent of an equity security.
284-26-050	Disclaimer of beneficial ownership.
284-26-060	Exemptions from RCW 48.08.110 and 48.08.120.
284-26-070	Exemption from the act of securities purchased or sold by odd-lot dealers.
284-26-080	Certain transactions subject to RCW 48.08.110.
284-26-090	Ownership of securities held in trust.
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284-26-110	Exemption from RCW 48.08.120 of transactions which need not be reported under RCW 48.08.110.
284-26-120	Exemption from RCW 48.08.120 of certain transactions effected in connection with a distribution.
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.
284-26-140	Exemption from RCW 48.08.120 of certain transactions in which securities are received by redeeming other securities.
284-26-150	Exemption of long-term profits incident to sales within six months of the exercise of an option.
284-26-160	Exemption from RCW 48.08.120 of certain acquisitions and dispositions of securities pursuant to merger or consolidations.
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.
284-26-180	Exemption from RCW 48.08.120 of certain transactions involving the conversion of equity securities.
284-26-190	Exemption from RCW 48.08.120 of certain transactions involving the sale of subscription rights.
284-26-200	Exemption of certain securities from RCW 48.08.130.
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

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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 twelve 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

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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 twenty-five 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

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(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

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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 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;

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(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 consol-

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idation 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 provisions of RCW 48.08.130 by this section. However, the performance of the functions of manager of a distributing

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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

284-28-010	Application of regulation.
284-28-020	Proxies, consents, and authorizations.
284-28-030	Disclosure of equivalent information.
284-28-040	Definitions.
284-28-050	Information to be furnished to stockholders.
284-28-060	Requirements as to proxy, and information statement.
284-28-070	Material required to be filed.
284-28-080	False or misleading statements.
284-28-090	Prohibition of certain solicitations.
284-28-100	Special provisions applicable to election contests.
284-28-110	Effective date.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

284-28-001 Promulgation. [Order R-69-2, § 284-28-001, filed 2/5/69; Regulation 246, filed 9/24/65, effective 11/1/65.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.

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 or 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.]

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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

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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 stockholders, 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

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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, distribu-

tion 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 stockhold-

ers 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 rea-

sons 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

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- 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.
- 284-30-360 Failure to acknowledge pertinent communications.
- 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 Regulation of settlements of insurance claims relating to vehicles.

284-30-3901	Definitions for settlement of vehicle claims.
284-30-3902	When my vehicle is repairable, what can I expect from the insurer?
284-30-3903	Can I get my vehicle repaired at a shop of my choice?
284-30-3904	Will my insurer pursue collection of my deductible?
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284-30-3908	Are there factors that may adjust my settlement?
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TRADE PRACTICES

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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.
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MILITARY SALES PRACTICES

284-30-850	Authority, purpose, and effective date.
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284-30-900	Purpose.
284-30-905	Scope.
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284-30-920	Procedures for resolving lost policy disputes regarding environmental claims.

284-30-930	Specific unfair environmental claims settlement or trade practices defined.
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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

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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.

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(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 fifteen 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 fifteen 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 refer-

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ence 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 Regulation of settlements of insurance claims relating to vehicles. WAC 284-30-390 through 284-30-3916 are the standards for prompt, fair, and equitable settlements for insurance claims relating to vehicles.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-390, filed 6/30/03, effective 10/1/03. 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 284-30-3901 Definitions for settlement of vehicle claims. In addition to the definitions in WAC 284-30-320, the following definitions apply to WAC 284-30-3901 through 284-30-3916.

(1) "Actual cash value" means the cost to you to replace your vehicle with a comparable vehicle.

(2) "Comparable vehicle" means a vehicle that is the same make and model, same or newer year, similar body style, similar options and mileage as your vehicle and in as good or better overall condition as established by current data. To achieve comparability, any deductions or additions

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for options, mileage or condition can only be made if they are itemized and appropriate in dollar amount. An insurer must consider information supplied by you when determining deductions or additions.

(3) "Current data" means data no older than ninety days from the date of loss.

(4) "Principally garaged" means the zip code where the vehicle is normally kept.

(5) "Settlement" means when the payment is actually made to you and/or your lien holder.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3901, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3902 When my vehicle is repairable, what can I expect from the insurer? (1) The insurer must provide you a copy of the itemized estimate it is using as the basis for payment.

(2) Upon your request, the insurer must provide you names of repair shops within your principally garaged area that will satisfactorily complete the repairs for the estimated cost.

(3) The insurer cannot require you to travel unreasonably to:

- (a) Obtain a repair estimate;
- (b) Have the vehicle repaired at a specific repair shop; or
- (c) Obtain a temporary rental or loaner vehicle.

(4) Deductions for betterment and depreciation may be taken only for parts normally subject to repair and replacement during the useful life of the insured motor vehicle. Deductions for betterment and depreciation are limited to the increase in the actual cash value of the vehicle caused by the replacement of the part, or the 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, whichever is less.

(5) Your insurer may elect to exercise its right, under the terms of your insurance contract, to repair your vehicle and designate a specific repair shop for your vehicle repairs. In this case, your insurer must restore your vehicle to its condition prior to the loss at no additional cost to you other than as stated in your policy.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3902, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3903 Can I get my vehicle repaired at a shop of my choice? (1) The insurer must make a good faith effort to honor your request for repairs to be made in a specific repair shop and cannot arbitrarily deny your request.

(2) A denial of your request solely because of the repair shop's hourly rate is arbitrary if the rate does not result in a higher overall cost of repairs.

(3) If the overall cost of repairs cannot be agreed upon, the insurer will:

(a) Provide you with the names of reputable repair shops reasonably close to you that can satisfactorily complete the repairs for the amount of their estimate; and

(b) Make an appropriate notation in its claim file setting forth the reason it has rejected your request.

(4) If you choose to take your vehicle to a repair facility in which the overall cost for a satisfactory repair is higher than the insurer's estimate, you may be liable for any additional amount above their estimate.

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[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3903, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3904 Will my insurer pursue collection of my deductible? (1) Yes, if your insurer is pursuing collection of its interest, you may request they pursue collection of your deductible for you.

(2) Your insurer will inform you of its efforts relative to collection of your deductible.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3904, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3905 If my insurer collects my deductible back, will I recover the full amount of my deductible?

(1) At a minimum, recovery will be shared on a proportionate basis with your insurer.

(2) No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery, and then only for the pro rata share of the allocated loss adjustment expense.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3905, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3906 If another party is responsible for my vehicle damage, can that party's insurer refuse to settle my vehicle damage and force me to use my own collision coverage? When liability and damages are reasonably clear, another party's insurer cannot recommend that you make a claim under your own collision coverage solely to avoid paying the claim.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3906, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3907 How can my insurer settle my vehicle total loss claim? Your insurer can adjust and settle vehicle total losses by one of the following methods:

(1) Replacing your vehicle: Your insurer can settle your claim by offering to replace your vehicle with a comparable vehicle that is available for inspection within a reasonable distance from where your vehicle is principally garaged. Your insurer must advise you by phone or in writing of their settlement offer. This communication must be documented in the claim file. If it is a phone call, the documentation must include the date, time, and name of the person in your household they spoke with.

(2) Cash settlement: Your insurer can settle your claim by offering a cash settlement based on the actual cash value to purchase a comparable vehicle. Only vehicles identified as comparable may be used to arrive at the actual cash value. You can request a copy of the "valuation report" that notes the information used to determine the amount of the cash settlement. The offer of a cash settlement must use one of the following methods:

(a) The actual cash value of a comparable vehicle based on current data obtained from the principally garaged area. If a comparable vehicle cannot be found within the principally garaged area, the search area may be expanded only in increasing circles of twenty-five mile increments until a comparable vehicle is identified.

(b) Quotations for the actual cash value of a comparable vehicle obtained from two or more licensed dealers located

within the principally garaged area. If two or more licensed dealers cannot be found within the principally garaged area, the search area may be expanded only in increasing circles of twenty-five mile increments until two or more quotes for comparable vehicles are obtained.

(c) The actual cash value of two or more comparable vehicles advertised for sale in the local media if the advertisements are no older than ninety days. The vehicle must be located within the principally garaged area. If two or more comparable vehicles cannot be found within the principally garaged area, the search area may be expanded only in increasing circles of twenty-five mile increments until two or more comparable vehicles are identified.

(d) Any source for determining statistically valid actual cash values within your vehicle's principally garaged area that meets all of the following criteria:

(i) The source must give primary consideration to the values of vehicles in the zip code where your vehicle was principally garaged.

(ii) The source's data base must produce values for at least eighty-five percent of all makes and models for a minimum of fifteen years taking into account the values of all major options for such vehicles.

(iii) The source must produce actual cash values based on current data available from the principally garaged area. If comparable vehicles cannot be found within the principally garaged area, the search area may be expanded until comparable vehicles are identified to assure statistical validity.

(iv) The source must rely upon the actual cash value of comparable vehicles that are currently available or were available in the market place within ninety days from the date of loss.

(v) Any adjustments for betterment or depreciation must be in compliance with WAC 284-30-3908.

(vi) The source must provide a list of the comparable vehicles used to determine the actual cash value. If more than thirty comparable vehicles are used, only thirty must be listed.

(e) When you and your insurer both agree, an evaluation that varies from the methods described in (a) through (d) of this subsection may be used. The determination of value must be supported by documentation. Your insurer must take reasonable steps to validate that the value so determined is accurate and representative of what the actual cash value would be of a comparable vehicle in the principally garaged area.

(f) Insurers remain responsible for the accuracy of evaluations based on outside sources used to establish actual cash values.

(3) Appraisal: If you and your insurer fail to agree on the actual cash value of your vehicle and your policy has an appraisal provision, you or your insurer may request that the appraisal provision of your policy be used as a method to resolve disputes concerning the actual cash value.

(4) Applicable taxes, license fees, and other fees incidental to transfer of evidence of ownership must be added to the actual cash value.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3907, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3908 Are there factors that may adjust my settlement? Your settlement may be adjusted by one of the following methods:

(1) Deductions are allowable for prior unrepaired damage. The amount of deduction can be no greater than the decrease in actual cash value due to prior damage.

(2) When you retain your total loss vehicle, your insurer may deduct the salvage value from the actual cash value, including all applicable taxes and fees. At your request, the insurer must provide you with the name and address of a salvage dealer or dismantler who will purchase the salvage for the amount deducted with no additional charge. This option must be available for at least thirty days after receipt of the settlement. This option will not be available if, after settlement, the condition of the salvage has been changed.

(3) Any additions or deductions from the actual cash value must be measurable, discernible, itemized and specified as to dollar amounts.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3908, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3909 If my vehicle is determined to be a total loss, can I keep it? (1) If your claim is being handled by another person's liability insurer, you may negotiate to keep your vehicle.

(2) If your claim is being handled under your insurance policy, it will depend on the terms and conditions in your policy.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3909, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3910 Can the insurer move my vehicle prior to settlement of the claim? Yes, the insurer may move your vehicle with your consent. An insurer may seek to move your vehicle to eliminate additional storage costs. If you do not consent to move your vehicle, you may be held liable for those additional storage costs.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3910, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3911 What information must be included in the insurer's valuation report? The valuation report must include:

(1) All information collected during the initial inspection that sets forth the condition, equipment, and mileage of your vehicle;

(2) All information that the insurer used to arrive at your actual cash value of the vehicle;

(3) A list of the comparable vehicles used by the insurer to arrive at the actual cash value. This list must include:

(a) The source of the information used;

(b) The date of the information;

(c) The seller's telephone number;

(d) The asking price;

(e) The sold price, if the sold price is available and verified;

(f) The location of each vehicle at the time of the valuation.

(g) When an insurer uses a source for determining statistically valid actual cash values meeting the requirements of WAC 284-30-3907 (2)(d), the insurer must give primary con-

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sideration to vehicles in the zip code where your vehicle was principally garaged. If more than thirty comparable vehicles are used, only thirty must be listed.

Any supplemental or ancillary information must be clearly identified with a separate heading. Any weighing of identified vehicles to arrive at an average must be documented and explained.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3911, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3912 What if I, as an insured, accept the settlement based on my insurer's valuation and cannot find a comparable vehicle within a reasonable distance of my vehicle's principally garaged area? (1) When you accept the settlement, your insurer must provide you with written notice regarding reopening of your claim file.

(2) If you notify your insurer within thirty-five days of receipt of the settlement that you cannot purchase a comparable vehicle for the settlement amount and you located, but did not purchase a comparable vehicle that costs more than the settlement amount, your insurer must reopen your claim file and either:

(a) Locate a comparable vehicle that is currently available for the settlement amount;

(b) Pay you the difference between the settlement amount and the cost of the comparable vehicle or purchase the comparable vehicle for you; or

(c) If not previously utilized, conclude the loss settlement in the manner provided in the appraisal section of your insurance policy in force at the time of the loss.

(3) Your insurer is not required to reopen your claim file if:

(a) At the time of settlement, you were provided written notification of the availability and location of a specific and comparable vehicle that could have been purchased for the settlement amount; and

(b) You did not purchase the vehicle within three days of the receipt of the settlement.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 04-01-176 (Matter No. R 2003-07), § 284-30-3912, filed 12/23/03, effective 1/23/04; 03-14-092 (Matter No. R 2002-06), § 284-30-3912, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3913 What must the insurer do prior to the denial of storage and towing costs? The insurer must:

(1) Advise you by phone or in writing before they stop payment for storage of your vehicle. This communication must be documented in the claim file. If it is a phone call, the documentation must include the date, time, name of the person in your household they spoke with, and specifics of the conversation;

(2) Provide reasonable time, in no event greater than five business days, for you to remove your vehicle from storage before stopping payment; and

(3) Pay any and all reasonable towing charges unless otherwise provided in your policy. You may use any towing company unless the insurer provides you with the name of a specific towing company before your vehicle is towed.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3913, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3914 When I am dealing with someone else's insurer, what are my rights regarding a rental vehicle? In vehicle property damage liability claims in which liability is reasonably clear, the insurer will negotiate the reasonable and necessary costs in direct proportion to the extent of its liability for the rental of another vehicle and may not require you to rent a vehicle to actually cover these costs.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3914, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3915 What if the other person's insurer offers a flat rental amount per day, week, or month? When the insurer offers a flat rental amount per day, week, or month, they must disclose to you where you can obtain a vehicle for the amount of its payment.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3915, filed 6/30/03, effective 10/1/03.]

WAC 284-30-3916 In a total loss situation, what happens if I have a loan or lease on my vehicle and the outstanding balance exceeds the actual cash value of my vehicle? Unless you have purchased auto loan/lease gap coverage, you will be responsible for the difference between the actual cash value of your vehicle and the outstanding balance owing to the lessor or finance company if your vehicle is a total loss. For example, if your vehicle's actual cash value is \$15,000 but you owe \$20,000 to the lessor or finance company, you will be responsible for the extra \$5,000. Your insurer is not required to pay the difference unless you have purchased specific coverage for it, subject to your policy's terms and conditions.

[Statutory Authority: RCW 48.02.060, 48.30.010. 03-14-092 (Matter No. R 2002-06), § 284-30-3916, filed 6/30/03, effective 10/1/03.]

WAC 284-30-395 Standards for prompt, fair and equitable settlements applicable to automobile personal injury protection insurance. The commissioner finds that some insurers limit, terminate, or deny coverage for personal injury protection insurance without adequate disclosure to insureds of their bases for such actions. To eliminate unfair acts or practices in accord with RCW 48.30.010, 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 automobile personal injury protection insurance. The following standards apply to an insurer's consultation with health care professionals when reviewing the reasonableness or necessity of treatment of the insured claiming benefits under his or her automobile personal injury protection benefits in an automobile insurance policy, as those terms are defined in RCW 48.22.005 (1), (7), and (8), and as prescribed at RCW 48.22.085 through 48.22.100. This section applies only where the insurer relies on the medical opinion of health care professionals to deny, limit, or terminate medical and hospital benefit claims. When used in this section, the term "medical or health care professional" does not include an insurer's claim representatives, adjusters, or managers or any health care professional in the direct employ of the insurer.

(1) Within a reasonable time after receipt of actual notice of an insured's intent to file a personal injury protection medical and hospital benefits claim, and in every case prior to

denying, limiting, or terminating an insured's medical and hospital benefits, an insurer shall provide an insured with a written explanation of the coverage provided by the policy, including a notice that the insurer may deny, limit, or terminate benefits if the insurer determines that the medical and hospital services:

- (a) Are not reasonable;
- (b) Are not necessary;
- (c) Are not related to the accident; or
- (d) Are not incurred within three years of the automobile accident.

These are the only grounds for denial, limitation, or termination of medical and hospital services permitted pursuant to RCW 48.22.005(7), 48.22.095, or 48.22.100.

(2) Within a reasonable time after an insurer concludes that it intends to deny, limit, or terminate an insured's medical and hospital benefits, the insurer shall provide an insured with a written explanation that describes the reasons for its action and copies of pertinent documents, if any, upon request of the insured. The insurer shall include the true and actual reason for its action as provided to the insurer by the medical or health care professional with whom the insurer consulted in clear and simple language, so that the insured will not need to resort to additional research to understand the reason for the action. A simple statement, for example, that the services are "not reasonable or necessary" is insufficient.

(3)(a) Health care professionals with whom the insurer will consult regarding its decision to deny, limit, or terminate an insured's medical and hospital benefits shall be currently licensed, certified, or registered to practice in the same health field or specialty as the health care professional that treated the insured.

(b) If the insured is being treated by more than one health care professional, the review shall be completed by a professional licensed, certified, or registered to practice in the same health field or specialty as the principal prescribing or diagnosing provider, unless otherwise agreed to by the insured and the insurer. This does not prohibit the insurer from providing additional reviews of other categories of professionals.

(4) To assist in any examination by the commissioner or the commissioner's delegatee, the insurer shall maintain in the insured's claim file sufficient information to verify the credentials of the health care professional with whom it consulted.

(5) An insurer shall not refuse to pay expenses related to a covered property damage loss arising out of an automobile accident solely because an insured failed to attend, or chose not to participate in, an independent medical examination requested under the insured's personal injury protection coverage.

(6) If an automobile liability insurance policy includes an arbitration provision, it shall conform to the following standards:

(a) The arbitration shall commence within a reasonable period of time after it is requested by an insured.

(b) The arbitration shall take place in the county in which the insured resides or the county where the insured resided at the time of the accident, unless the parties agree to another location.

(c) Relaxed rules of evidence shall apply, unless other rules of evidence are agreed to by the parties.

(d) The arbitration shall be conducted pursuant to arbitration rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, Washington Arbitration and Mediation Service, chapter 7.04 RCW, or any other rules of arbitration agreed to by the parties.

[Statutory Authority: RCW 48.02.060, 48.22.105 and 48.30.010. 97-13-005 (Matter No. R 96-6), § 284-30-395, filed 6/5/97, effective 7/6/97.]

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

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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 approved 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) The following practices by any insurer

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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 applicable 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) With respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, failing to provide a named insured an itemization of the premium costs for the coverages under the policy if there are identifiable separate premium charges for the coverages is unfair and prohibited. The required itemization must be given to a named insured no later than at the time of delivery of a policy and must accompany each offer to renew thereafter.

(3) It is 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. 07-19-106 (Matter No. R 2007-07), § 284-30-500, filed 9/19/07, effective 10/20/07. 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.]

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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 non-renewal of an insurance policy followed by its offer to rewrite 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 mid-term 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) Under RCW 48.30.010, it is an unfair method of competition and an unfair practice for any insurer to engage in any insurance transaction, as defined in RCW 48.01.060, regarding life insurance, annuities, or disability insurance coverage on individuals in this state under a group policy delivered to a policyholder outside this state when:

(a) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, 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 or certificate.

(b) The policy or certificate providing coverage in the state of Washington, including, but not limited to, applications, riders, or endorsements, has any title, heading, or other indication of its provisions which is misleading.

(c) The policy or certificate delivered to residents of the state of Washington does not include all terms and conditions of the coverage.

(d) The type of group being covered under the contract providing coverage in the state of Washington does not qualify for group life insurance or group disability insurance under the provisions of Title 48 RCW.

(e) The coverage is being solicited by deceptive advertising.

(f) With respect to disability insurance, the policy or certificate providing coverage in the state of Washington does not:

(i) Provide that claims will be processed in compliance with RCW 48.21.130 through 48.21.148;

(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, 284-30-620 and 284-30-630;

(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 under RCW 48.66.100 and 48.70.030 and chapter 284-60 WAC.

(g) With respect to life insurance, the out-of-state group policy or certificate providing coverage in the state of Washington fails to comply with the provisions of:

(i) Chapter 48.24 RCW;

(ii) WAC 284-23-550 and 284-23-600 through 284-23-730;

(iii) WAC 284-30-620; and

(iv) WAC 284-30-630.

(2) Except as provided in subsection (3)(c) of this section, for purposes of this section it is immaterial whether the coverage is offered by means of a solicitation through: A sponsoring organization; the mail broadcast or print media; electronic communication, including electronic mail and websites; licensed agents or brokers; or any other method of communication.

(3) It is further defined to be an unfair practice for any insurer marketing group insurance coverage in this state to do the following with respect to the coverage:

(a) To fail to comply with the requirements of this state relating to advertising and claims settlement practices, and to fail to furnish the commissioner, upon request, copies of all advertising materials intended for use in this state;

(b) To fail to file copies of all certificate forms and any other related forms providing coverage in Washington,

including trust documents or articles of incorporation with the commissioner at least thirty days prior to use; and

(c) To fail to file with the commissioner a copy of the disclosure statement required by WAC 284-30-610, where the sale of coverage to individuals in this state will be through solicitation by agents, solicitors or brokers. The disclosure statement must be appropriately completed, as it appears when delivered to the Washington individuals who are solicited by the Washington licensees.

The disclosure form must also be filed at least thirty days prior to any solicitation of coverage.

(4) This section does not apply to self-funded plans that are defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA) or to insurers when acting as third-party administrators for self-funded ERISA plans.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.020, 48.01.060, 00-19-048 (Matter R 98-18), § 284-30-600, filed 9/14/00, effective 10/15/00. 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 insurer to permit its appointed licensed agent;
- An insurance agent;
- Solicitor; or
- A broker,

to solicit an individual in the state of Washington to buy or apply for life insurance, annuities, or disability insurance coverage when the coverage is provided under the terms of a group policy delivered to an association or organization (or to a trustee designated by the association or organization), as policyholder, outside this state, 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 brought to the attention of the individual being solicited before the application for coverage is completed and signed. The disclosure form must be signed by both the soliciting licensee and the individual being solicited and it must be given to the individual.

(b) A copy of the completed disclosure statement must be submitted by the soliciting licensee, with the application for coverage, to the insurer providing the coverage.

(c) The insurer must confirm the accuracy of the form's contents, and retain the copy for not less than three years from the date the coverage commences or from the date received, whichever is later.

(2) Disclosure statement form: (Type size to be no less than ten-point)

(Insurer's name and address)

IMPORTANT INFORMATION ABOUT THE COVERAGE 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

coverage offered to you under a group policy issued by (insurer), (to/on behalf of) (association or organization).

The policy is subject to and governed by the laws of the state of

The certificate of coverage issued to you is governed by the state of Washington.

The Washington State Insurance Commissioner has authority to assist you concerning your coverage.

To keep this 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 premiums to pay.

The 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 policy.

(Group organization's name) (will/will not) be paid for its participation in this insurance program. (An explanation of payments must be inserted here.)

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 (month), (year), by

(Signed) (agent, solicitor or broker).

Printed Name:

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THIS DISCLOSURE STATEMENT: 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, 48.24.080, 48.24.090, or 48.24.095.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.020, 48.01.060, 00-19-048 (Matter R 98-18), § 284-30-610, filed 9/14/00, effective 10/15/00. 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.]

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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

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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.]

MILITARY SALES PRACTICES

WAC 284-30-850 Authority, purpose, and effective date. In order to prevent unfair methods of insurance sales to active duty service members of the United States armed forces, unfair competition, and unfair or deceptive acts or practices by insurers, fraternal benefit societies, agents, brokers or solicitors, WAC 284-30-850 through 284-30-872 are adopted. These rules may be called the "military sales practices" rules.

(1) The Military Personnel Financial Services Protection Act (P.L. 109-290) was enacted by the 109th Congress to protect members of the United States armed forces from unscrupulous practices regarding the sale of insurance, financial, and investment products on and off military installations. The act requires this state to adopt rules that meet sales practice standards adopted by the National Association of Insurance Commissioners to protect members of the United States armed forces from dishonest and predatory insurance sales practices both on and off of a military installation.

(2) Based on the commissioner's authority under RCW 48.30.010 to define by rule methods of competition and other acts and practices in the conduct of the business of insurance found by the commissioner to be unfair or deceptive, after evaluation of the acts and practices of insurers, fraternal benefit societies, agents, brokers, or solicitors that informed the need for P.L. 109-290, and because the commissioner is required by that act to adopt rules that meet the sales practice standards adopted by the National Association of Insurance Commissioners and federal law, the commissioner finds the acts or practices set forth in WAC 284-30-850 through 284-30-872 to be unfair or deceptive methods of competition or unfair or deceptive acts or practices in the business of insurance.

(3) These military sales practices rules are effective for all benefit contracts, insurance policies and certificates solicited, issued, or delivered in this state on and after (the effective date of these rules).

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-850, filed 8/20/07, effective 9/20/07.]

WAC 284-30-855 Scope. WAC 284-30-850 through 284-30-872 affect all life insurance policies and certificates solicited or sold to an active duty service member of the United States armed forces or his or her dependent.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-855, filed 8/20/07, effective 9/20/07.]

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WAC 284-30-860 Exemptions. (1) The following life insurance solicitations or sales are exempt from the requirements of WAC 284-30-850 through 284-30-872:

(a) Credit life insurance.

(b) Group life insurance where there is no in-person face-to-face solicitation of individuals by a licensed agent, broker, or solicitor or where the policy or certificate does not include a side fund.

(c) An application to the insurer that issued the existing policy or certificate when a contractual change or a conversion privilege is being exercised; or when the existing insurance policy or certificate is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term life conversion privilege is exercised among corporate affiliates.

(d) Individual, stand-alone policies of health or disability income insurance.

(e) Contracts offered by Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI), as authorized by 38 U.S.C. section 1965 et seq., and contracts offered by State Sponsored Life Insurance (SSLI) as authorized by 37 U.S.C. Section 707 et seq.

(f) Life insurance policies or certificates offered through or by a nonprofit military association, qualifying under section 501(c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer.

(g) Contracts used to fund any of the following:

(i) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(ii) A plan described by sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the IRC, as amended, if established or maintained by an employer;

(iii) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the IRC;

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(v) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(vi) Prearranged funeral contracts.

(2) Nothing in WAC 284-30-850 through 284-30-872 shall be construed to restrict the ability of nonprofit organizations or other organizations to educate members of the United States armed forces in accordance with federal Department of Defense Instruction 1344.07 "Personal Commercial Solicitation on DOD Installations," or any successor directive.

(3)(a) For purposes of the military sales practices rules, general advertisements, direct mail and internet marketing do not constitute "solicitation." Telephone marketing does not constitute "solicitation" only if the caller explicitly and conspicuously discloses that the product being solicited is life insurance and the caller makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.

(b) Nothing in this section shall be construed to exempt an insurer, agent, broker, or solicitor from the military sales practices rules in any in-person face-to-face meeting estab-

lished as a result of the solicitation exemptions listed in this section.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-860, filed 8/20/07, effective 9/20/07.]

WAC 284-30-865 Definitions. The following definitions apply to the military sales practices rules, unless the context clearly requires otherwise:

(1) "Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component, such as national guard or reserve, while serving under published orders for active duty or full-time training. This term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of fewer than thirty-one calendar days.

(2) "Department of Defense (DOD) personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(3) "Door-to-door" means a solicitation or sales method whereby an agent, broker, or solicitor proceeds randomly or selectively from household to household without a prior specific appointment.

(4) "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance or the promotion of an insurer, agent, broker, or solicitor.

(5) "Insurer" means an insurance company, as defined in RCW 48.01.050, that provides life insurance products for sale in this state. The term "insurer" also includes fraternal benefit societies, as defined at RCW 48.36A.010. Whenever the term "insurer," "policy," or "certificate" is used in these military sales practices rules, it includes insurers and fraternal benefit societies and applies to all insurance policies, benefit contracts, and certificates of life insurance issued by them.

(6) "Known" or "knowingly" means, depending on its use in WAC 284-30-870 and 284-30-872, that the insurer or agent, broker, or solicitor had actual awareness, or in the exercise of ordinary care should have known at the time of the act or practice complained of that the person being solicited is either:

- (a) A service member; or
- (b) A service member with a pay grade of E-4 or below.

(7) "Life insurance" has the meaning set forth in RCW 48.11.020.

(8) "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(9) "MyPay" means the Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(10) "Service member" means any active duty officer (commissioned and warrant) or any enlisted member of the United States armed forces.

(11) "Side fund" means a fund or reserve that is part of or is attached to a life insurance policy or certificate (except for individually issued annuities) by rider, endorsement, or other

mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(a) Accumulated or cash value or secondary guarantees provided by a universal life policy;

(b) Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(c) A premium deposit fund which:

(i) Contains only premiums paid in advance which accumulate at interest;

(ii) Imposes no penalty for withdrawal;

(iii) Does not permit funding beyond future required premiums;

(iv) Is not marketed or intended as an investment; and

(v) Does not carry a commission, either paid or calculated.

(12) "Specific appointment" means a prearranged appointment that has been agreed upon by both parties and is definite as to place and time.

(13) "United States armed forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-865, filed 8/20/07, effective 9/20/07.]

WAC 284-30-870 Practices declared to be unfair or deceptive when committed on a military installation. (1)

The following acts or practices by an insurer, agent, broker, or solicitor are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance when committed on a military installation and solicited in-person face-to-face:

(a) Knowingly soliciting the purchase of any life insurance policy or certificate door to door or without first establishing a specific appointment for each meeting with the prospective purchaser.

(b) Soliciting service members in a group or mass audience or in a captive audience where attendance is not voluntary.

(c) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(d) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing, or other areas where the installation commander has prohibited solicitation.

(e) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(f) Posting unauthorized bulletins, notices, or advertisements.

(g) Failing to present DD Form 2885 Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(h) Knowingly accepting an application for life insurance or issuing a policy or certificate of life insurance on the life of an enlisted member of the United States armed forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement related to the sale of life insurance established by regulations,

directives, or rules of the DOD or any branch of the United States armed forces.

(2) The following acts or practices by an insurer, agent, broker, or solicitor are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance or improper influences or inducements when committed on a military installation:

(a) Using DOD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(b) Using an agent, broker, or solicitor to participate in any education or orientation program sponsored by United States armed forces.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-870, filed 8/20/07, effective 9/20/07.]

WAC 284-30-872 Practices declared to be unfair or deceptive regardless of where they occur. (1) The following acts or practices by an insurer, agent, broker, or solicitor are found by the commissioner and declared to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance or improper influences or inducements regardless of the location where they occur:

(a) Submitting, processing, or assisting in the submission or processing of any allotment form or similar device used by the United States armed forces to direct a service member's pay to a third party for the purchase of life insurance. For example, the using or assisting in the use of a service member's "MyPay" account or other similar internet or electronic medium to pay for life insurance is prohibited. For purposes of these military sales practices rules, assisting a service member by providing insurer or premium information necessary to complete any allotment form is not an unfair, deceptive, or prohibited practice.

(b) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(i) Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and regulations promulgated thereunder; and

(ii) Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(c) Employing any device or method, or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's leave and earnings statement (or equivalent or successor form) as "savings" or "checking" and where the service member has no formal banking relationship.

(d) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

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(e) Using DOD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to their family members.

(f) Offering or giving anything of value, directly or indirectly, to DOD personnel to procure their assistance in encouraging, assisting, or facilitating the solicitation or sale of life insurance to another service member.

(g) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

(h) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or state of legal residence for the sole purpose of increasing disposable income in order to purchase life insurance.

(2) The following acts or practices by an insurer, agent, broker, or solicitor may lead to confusion regarding the source, sponsorship, approval, or affiliation of the insurer or any agent, broker or solicitor. They are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation, or using any device, title, descriptive name, or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, agent, broker, or solicitor, or the policy or certificate offered is affiliated, connected, or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government, the United States armed forces, or any state or federal agency or governmental entity.

(i) For example, the use of the following titles, including but not limited to the following is prohibited: Battalion insurance counselor, unit insurance advisor, Servicemen's Group Life Insurance conversion consultant, or veteran's benefits counselor.

(ii) A person is not prohibited from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Examples include, but are not limited to the following: Chartered life underwriter (CLU), chartered financial consultant (ChFC), certified financial planner (CFP), master of science in financial services (MSFS), or masters of science financial planning (MS).

(b) Soliciting the purchase of any life insurance policy or certificate through the use of or in conjunction with any third-party organization that promotes the welfare of or assists members of the United States armed forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, agent, broker, solicitor, or the insurance policy or certificate is affiliated, connected, or associated with endorsed, sponsored, sanctioned, or recommended by the U.S. government, or the United States armed forces.

(3) The following acts or practices by an insurer, agent, broker, or solicitor lead to confusion regarding premiums, costs, or investment returns. They are each found by the commissioner to be false, misleading, unfair or deceptive meth-

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ods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(b) Misrepresenting the mortality costs of a life insurance policy or certificate (except for individually issued annuities), including stating or implying that the policy or certificate costs nothing or is free.

(4) The following acts or practices by an insurer, agent, broker, or solicitor regarding Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI) are each found by the commissioner to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation regarding the availability, suitability, amount, cost, exclusions, or limitations to coverage provided to service members or dependents by SGLI or VGLI, which is false, misleading, or deceptive.

(b) Making any representation regarding conversion requirements, including the costs of coverage, exclusions, or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading, or deceptive.

(c) Suggesting, recommending, or encouraging a service member to cancel or terminate his or her SGLI policy, or issuing a life insurance policy or certificate which replaces an existing SGLI policy unless the replacement takes effect upon or after separation of the service member from the United States armed forces.

(5) The following acts or practices regarding disclosure by an insurer, agent, broker, or solicitor are declared to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where the act occurs:

(a) Deploying, using, or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an agent, broker, or solicitor, if that is the case, for the purpose of soliciting the purchase of life insurance.

(b) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person face-to-face meeting with a prospective purchaser.

(c) Except for individually issued annuities, failing to clearly and conspicuously disclose the fact that the policy or certificate being solicited is life insurance.

(d) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act (P.L. 109-290), p. 16.

(e) Except for individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time of application is taken:

(i) An explanation of any free look period with instructions on how to cancel any policy or certificate issued by the insurer; and

(ii) Either a copy of the application or a written disclosure. The copy of the application or the written disclosure must clearly and concisely set out the type of life insurance, the death benefit applied for, and its expected first year cost. A basic illustration that meets the requirements of this state will be considered a written disclosure.

(6) The following acts or practices by an insurer, agent, broker, or solicitor are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Except for individually issued annuities, recommending the purchase of any life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

(b) Offering for sale or selling a life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(i) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate, survivors, or dependents.

(ii) Other military survivor's benefits include, but are not limited to: The death gratuity, funeral reimbursement, transition assistance, survivor and dependents' educational assistance, dependency and indemnity compensation, TRICARE healthcare benefits, survivor housing benefits and allowances, federal income tax forgiveness, and Social Security survivor benefits.

(c) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which includes a side fund:

(i) Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(ii) Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined policy or certificate. For this disclosure, the effective rate of return must consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule must be provided for at least each policy year from year one to year ten and for every fifth policy year thereafter, ending at age one hundred, policy maturity, or final expiration; and

(iii) Which by default diverts or transfers funds accumulated in the side fund to pay, reduce, or offset any premiums due.

(d) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which after considering all policy benefits, including but not limited

to endowment, return of premium, or persistency, does not comply with standard nonforfeiture law for life insurance.

(e) Selling any life insurance policy or certificate to a person known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service, except for accidental death coverage (for example, double indemnity) which may be excluded.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-872, filed 8/20/07, effective 9/20/07.]

ENVIRONMENTAL CLAIMS

WAC 284-30-900 Purpose. (1) There are many insurance coverage disputes involving Washington insureds who face potential liability for their roles at polluted sites in this state. State and federal mandates exist for cleaning up the environment in order to address the adverse effects of hazardous substances on human health and safety and the environment in general. It is in the public interest to reduce the costs incurred in connection with environmental claims and to expedite the resolution of such claims. The state of Washington has a substantial public interest in the timely, efficient, and appropriate resolution of environmental claims involving the liability of insureds at polluted sites in this state. This interest is based on practices favoring good faith and fair dealing in insurance matters and on the state's broader health and safety interest in a clean environment.

(2) Insureds and insurers alike face claims complicated by factual issues concerning events that occurred in the distant past. Many sites with environmental damage involve long-term operations with multiple owners; therefore, issues related to lost policies which may provide insurance coverage in the environmental claims context provide uniquely challenging problems of both lost evidence and witnesses.

(3) Cooperation between insureds and insurers in fairly and expeditiously resolving legitimate disputes and in reducing or eliminating nonmeritorious claims is in the public interest. Facilitating cooperation in resolving legitimate lost policy disputes in environmental claims will reduce unnecessary litigation, thereby freeing more resources for environmental cleanup. Insureds and insurers are encouraged to participate in a mediation program in order to achieve a mutually acceptable, expeditious resolution of environmental claims without resort to costly and lengthy litigation.

(4) This regulation is adopted to provide minimum standards for the conduct of insureds and insurers for presenting and resolving environmental claims with the goal of facilitating the fair, principled, and efficient resolution of environmental claims without resort to unnecessary, time-consuming, and expensive litigation.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-900, filed 4/10/95, effective 5/11/95.]

WAC 284-30-905 Scope. (1) This regulation applies to actions taken by an insurer on or after July 1, 1995, with regard to environmental claims arising under a general liability insurance policy issued to a Washington resident and concerning sites located within this state. This regulation does not apply to environmental claims for which coverage is

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resolved by judgment, settlement, or payment before July 1, 1995.

(2) This regulation is not exclusive, and acts or omissions, whether or not specified in WAC 284-30-900 through 284-30-940, may also be violations of other sections of the insurance code or other regulations promulgated thereunder.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-905, filed 4/10/95, effective 5/11/95.]

WAC 284-30-910 Definitions. As used in this regulation:

(1) "Environmental claim" means a claim for defense or indemnity submitted under a general liability insurance policy by an insured facing, or allegedly facing, potential liability for bodily injury or property damage to others arising from a discharge of pollutants into land, air, or water.

(2) "General liability insurance policy" means a contract of insurance that provides coverage for the legal obligations of an insured for bodily injury or property damage to others. It includes, for example, pollution insurance policies and comprehensive general liability insurance policies; it does not include insurance policies relating to motor vehicles, personal coverage such as homeowners, or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance, or other similar policies.

(3) "Insured" means a Washington resident who is either the named insured or is acting on behalf of a Washington resident who is a named insured, and is presenting an environmental claim.

(4) "Lost policy" includes general liability insurance policies that are alleged by an insured to be lost.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-910, filed 4/10/95, effective 5/11/95.]

WAC 284-30-920 Procedures for resolving lost policy disputes regarding environmental claims. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to investigate thoroughly and promptly all claims of lost policies. It is also an unfair practice or an unfair method of competition for an insurer to fail to provide all facts known or discovered during an investigation concerning the issuance and terms of a policy, including copies of documents establishing such facts, to an insured claiming coverage under a lost policy. A single violation of this section may be deemed by the commissioner to be an unfair act or practice or an unfair method of competition. The following procedures are minimum standards for the facilitation of reconstructing a lost policy and determining its terms. These procedures do not create a presumption of coverage for the loss once the contract is reconstructed.

(1) Within fifteen working days after receipt by the insurer of notice of a lost policy, an insurer shall commence an investigation into its records, including its computer records, to determine whether it issued the lost policy. If the insurer determines that it issued the policy in question, it shall promptly commence an investigation into the terms and conditions relevant to the environmental claim.

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(a) For purposes of this section, "notice of a lost policy" means written notice of the lost policy in sufficient detail to identify the person or entity seeking coverage, including information concerning the name of the alleged policyholder, if known, together with material facts known to the insured concerning the lost policy.

(b) Insureds and insurers shall fully cooperate with each other in the investigation of lost policy issues.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to the issuance or existence of a lost policy.

(ii) Each shall provide the other with copies of documents establishing facts related to the lost policy.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(2) If the insurer discovers information tending to show the issuance of a policy applicable to the claim, the following procedures shall apply:

(a) If the insurer is able to determine the terms of the policy, upon request the insurer shall provide to an insured an accurate copy or reconstruction of the policy or the portions of the policy located.

(b) If after diligent investigation the insurer is not able to locate all or part of the policy or to determine the terms, conditions, or exclusions of the policy, the insurer shall provide copies of all insurance policy forms potentially applicable to the environmental claim issued by the insurer during the applicable policy period. The insurer shall state which of the potentially applicable forms, if any, is most likely to have been issued and why, or alternatively, shall state why it is unable to identify the forms after a good faith search. Providing copies of forms and meeting the standards of this section, is neither an admission by an insurer that a policy was issued or effective, nor, if a policy were issued, that it was necessarily in the form produced, unless the insurer so states.

(c) If it is concluded that a general liability insurance policy more likely than not was issued to the insured by the insurer, and neither the insured nor the insurer can produce any evidence which may tend to show the policy limits applicable to the policy, it shall be assumed, in the absence of other evidence, that the minimum limits of coverage offered by the insurer during the period in question were purchased by the insured.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-920, filed 4/10/95, effective 5/11/95.]

WAC 284-30-930 Specific unfair environmental claims settlement or trade practices defined. The commissioner has found and hereby defines the following acts or practices related to the settlement of environmental claims to be unfair methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance. A single violation of this section may be deemed by the commissioner to be an unfair claims settlement practice, an unfair trade practice, or an unfair method of competition.

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(1) Failure to pay interest at the statutory rate as set by the state treasurer from time to time, pursuant to RCW 19.52.025:

(a) On payments that an insured has made and which the insurer is legally obligated to pay as damages: Provided however, That interest shall begin to accrue only when a claim is presented or payment is made by the insured, whichever is the later; or

(b) On overdue payments that an insurer agreed to make pursuant to an agreed settlement with an insured: Provided however, That interest shall begin to accrue on the thirty-first day after the date of the settlement or the agreed time, if later.

(2) Failure of an insurer to commence investigation of an environmental claim within fifteen working days after receipt of a notice of an environmental claim.

(a) Insureds and insurers shall fully cooperate with each other in the investigation of environmental claims.

(i) Each shall provide to the other facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to an environmental claim.

(ii) Each shall provide the other with copies of documents establishing facts related to an environmental claim.

(iii) Neither an insured nor an insurer shall be required to produce material subject to the attorney-client privilege or the work product doctrine, or confidential claims documents provided to the insurer by another policyholder.

(b) An excess insurer may rely on the investigation of a primary insurer.

(3) Failure to make payments, under its duty to defend, for costs reasonably incurred in an investigation to determine the source of contamination, the type of contamination, and the extent of the contamination.

(4) Denying a claim on the basis that the insured expected or intended the damage unless, to the best of the insurer's knowledge, information, and belief, formed after reasonable inquiry, the insurer's position is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

(5) Denying that there is damage to a site that is listed on the National Priorities List under the Comprehensive Environmental Response Compensation and Liabilities Act of 1980, 42 U.S.C. Sections 6901-6992k, or the hazardous sites list under the Model Toxics Control Act of Washington, chapter 70.105D RCW, if the federal Environmental Protection Agency or the state department of ecology has determined that there is actual damage on the site unless an insurer has evidence that no actual damage occurred. It should not be presumed that only sites on the National Priorities List or the hazardous sites list have environmental damage requiring action.

(6) Requiring the insured to provide answers to repetitive questions and requests for information concerning matters or issues unrelated to the insured's environmental claim. This does not prevent an insurer from clearly reserving its rights as to information that is not available at the time of the correspondence.

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[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-930, filed 4/10/95, effective 5/11/95.]

WAC 284-30-940 Environmental claim mediation program. The commissioner has found and hereby defines it to be an unfair act or practice or an unfair method of competition for an insurer to fail to participate in good faith in non-binding mediation requested by an insured concerning the existence, terms, or conditions of a lost policy, or regarding coverage for an environmental claim.

(1) The insured may request in writing that the insurer participate in nonbinding mediation.

(2) Upon request from an insured for nonbinding mediation, an insurer shall provide an insured with information concerning an environmental claim mediation program. The information shall include, but need not be limited to, a description of how an insured can efficiently commence a mediation program.

(3) The purposes of mediation shall include, but need not be limited to, the following:

(a) To assist the parties in resolving disputes concerning whether or not a general liability insurance policy applicable to the environmental claim was issued to the insured by the insurer or concerning the relevant terms, conditions, and exclusions of the policy;

(b) To determine whether the entire claim, or a portion thereof, can be settled by agreement of the parties;

(c) If the claim cannot be settled, to determine whether one or more issues can be resolved to the satisfaction of the parties; or

(d) To discuss any other methods of streamlining or reducing the cost of litigation.

(4) Mediation shall be conducted pursuant to mediation rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

(5) Unless otherwise agreed, information provided and statements made by either party in a mediation shall be kept confidential by the parties and used only for purposes of the mediation in accordance with RCW 5.60.070.

(6) Insureds and insurers shall have representatives present, or available by telephone, with authority to settle the matter at all mediation sessions.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.01.030, 48.05.280, 48.15.100 and 48.15.170. 95-09-014 (Order R 94-30), § 284-30-940, filed 4/10/95, effective 5/11/95.]

Chapter 284-34 WAC

CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

WAC

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284-34-250	What information must be disclosed to debtors?
284-34-260	What is the effective date of this regulation?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-34-010	Credit life insurance. [Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-020	Credit accident and health insurance. [Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-030	Collection and remittance of premiums. [Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-040	Rate filings and deviations from prima facie rates. [Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-050	Refunds. [Order R-75-4, § 284-34-050, filed 9/25/75; Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-060	Effective date—Implementation. [Order 324 (part), filed 9/26/67, effective 1/1/68.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.
284-34-070	Prohibited transactions. [Order R-76-5, § 284-34-070, filed 11/16/76.] Repealed by 05-02-076 (Matter No. R 2002-02), filed 1/4/05, effective 4/1/05. Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110.

WAC 284-34-100 What is the purpose of this regulation? The purpose of this regulation, WAC 284-34-100 through 284-34-260, is to protect debtors and the public by establishing a system of rate, policy form, and operating standards for the transaction of consumer credit insurance. This regulation interprets and implements the sections of Title 48 RCW that apply to consumer credit insurance, including, but not limited to, the following sections: RCW 48.02.060 (3)(a), 48.24.040 and chapter 48.34 RCW.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.110. 05-02-076 (Matter No. R 2002-02), § 284-34-100, filed 1/4/05, effective 4/1/05.]

WAC 284-34-110 What definitions are important throughout this regulation? (1) "Affiliate" has the same meaning as stated in RCW 48.31B.005(1).

(2) "Closed-end credit" means any credit transaction that does not meet the definition of open-end credit.

(3) "Control" has the same meaning as stated in RCW 48.31B.005(2).

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(4) **"Compensation"** means any form of payment that results directly from the sale of consumer credit insurance, including:

- (a) Commissions;
- (b) Dividends;
- (c) Equipment;
- (d) Expense allowances or reimbursements;
- (e) Experience refunds;
- (f) Facilities;
- (g) Gifts;
- (h) Goods or services;
- (i) Retrospective rate credits; or
- (j) Service fees.

(5) **"Consumer credit insurance"** means credit life insurance or credit accident and health insurance defined in RCW 48.34.030.

(6) **"Credit transaction"** means an agreement to:

- (a) Repay money loaned;
 - (b) Pay for a loan commitment made; or
 - (c) Pay for goods, services, or property sold or leased.
- Payment would be made at a future date or dates.

(7) **"Evidence of individual insurability"** means a statement furnished by the debtor related to:

- (a) The health status or health or medical history of the debtor;
- (b) The occupation of the debtor; or
- (c) Other conditions for the insurance to take effect.

Evidence of individual insurability does not include information related to the eligibility of the debtor for coverage.

(8) **"Loss ratio"** means incurred claims divided by the sum of earned premiums and imputed interest earned on unearned premiums. The commissioner imputes interest at the maximum rate permitted for the valuation of whole life insurance.

(9) **"Net debt"** means the amount needed to repay all remaining debt in a single payment. Net debt does not include unearned interest and other unearned finance charges.

(10) **"Open-end credit"** means a credit agreement in which the creditor:

- (a) Allows repeated transactions;
- (b) Applies finance charges to unpaid balances; and
- (c) May allow additional credit if part of the balance is repaid.

(11)(a) **"Preexisting condition"** means any condition for which the insured debtor received medical advice, consultation, or treatment.

(b) The insured debtor must have received the medical advice, consultation or treatment within six months before the insurance takes effect.

(c) The insured debtor must have become disabled within six months after the insurance takes effect.

(12) **"Premium"** means the same as RCW 48.18.170, and includes all forms of compensation.

(13) **"Underwriting"** means applying criteria under which the insurer:

- (a) Issues or refuses to issue;
- (b) Renews or refuses to renew; or
- (c) Limits coverage.

Underwriting includes decisions by the insurer based on eligibility criteria or evidence of individual insurability.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-110, filed 1/4/05, effective 4/1/05.]

WAC 284-34-120 What rights do debtors have? (1) A debtor has the right to know about all available credit insurance plans. The creditor must inform every debtor about:

- (a) Each plan of insurance for which the debtor is eligible; and
- (b) The premium or insurance charge for each plan of insurance.

(2) If the creditor requires consumer credit insurance, then the debtor has the right to provide alternative insurance coverage. The creditor must tell the debtor before the transaction is completed that the debtor may provide alternative insurance coverage. The debtor may:

- (a) Use existing insurance policies the debtor owns or controls; or
 - (b) Get coverage from any authorized insurer.
- (3) Debtor's rights when a policy of group consumer credit insurance ends:

(a) The insurer must continue coverage for the entire period for which a premium has been paid. This paragraph applies if the policy provides for:

- (i) Single premium payments; or
- (ii) Premium payments that prepay coverage beyond one month.

(b) The insurer must provide termination notice to the insured debtor at least thirty days before coverage ends. If the policy provides for monthly premium payments, the insurer does not have to provide termination notice if the debtor obtains equivalent coverage and no lapse of coverage occurs.

(4) For coverage on refinanced debt, all exclusions and policy limitations will apply as of the first date that the debtor first became insured for the original debt.

This subsection applies to the amount of debt and term of the debt outstanding on the day the debtor refinances.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-120, filed 1/4/05, effective 4/1/05.]

WAC 284-34-130 What obligations do insurers have? (1) If the creditor adds insurance charges or premiums to the debt, the insurer must collect the premium or charges within sixty days after it is added to the debt.

(2) If the debtor refinances and pays off the debt before the scheduled maturity date, the insurer must terminate existing insurance before any new insurance may be issued to provide coverage for the refinanced debt.

(3) If insurance coverage ends due to prepayment before the scheduled maturity date, the insurer must terminate coverage and comply with WAC 284-34-190 and refund all unearned insurance or premium charges and cause those amounts to be paid or credited to the debtor. The following exceptions apply:

(a) The insurer does not have to refund insurance charges or premiums for any coverage under which a lump sum insurance benefit is paid.

(b) The insurer does not have to refund insurance charges or premiums for any period of disability under which credit accident and health benefits are paid.

(c) The insurer must comply with WAC 284-34-170 (1)(d)(ii), which says that disability premium charges must be returned for the months following the billing month in which the disability occurred.

(4) The insurer may apply a maximum limit on total claim payments only to a specific individual policy or group certificate.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-130, filed 1/4/05, effective 4/1/05.]

WAC 284-34-140 How will the commissioner determine if benefits are reasonable in relation to premium charges? (1) Insurers must provide consumer credit insurance benefits that are reasonable in relation to the premium charged. This means that debtors must be provided reasonable benefits in return for their premium payments.

(a) The commissioner presumes that the rates in WAC 284-34-150 and 284-34-170, as adjusted under WAC 284-34-210, satisfy this standard. These rates allow:

(i) Sixty percent of premium for benefits on one debtor; and

(ii) Forty percent of premium for expenses and profit.

(b) If an insurer wants to use rates that are different than those in WAC 284-34-150 or 284-34-170, the insurer must file those rates under WAC 284-34-220.

(i) The commissioner must approve the alternative rates before they are used; and

(ii) The insurer must provide data that prove the alternative rates will result in reasonable benefits in relation to premium charges.

(2) The commissioner presumes excessive compensation requires premiums that are not reasonable in relation to benefits provided to debtors. The commissioner presumes that compensation is excessive if:

(a) Total compensation exceeds thirty percent of the net written prima facie premium; or

(b) More than twenty-five percent of net written prima facie premium is paid directly or indirectly to a creditor.

(3) If an insurer does not provide coverage to a debtor during a time period, the insurer may not charge premium for that period.

(4) If an insurer files any form providing coverage that is different from that described in WAC 284-34-150 through 284-34-180, the insurer must prove that the rates:

(a) Will develop a loss ratio of sixty percent; or

(b) Are actuarially consistent with the rates in WAC 284-34-150 and 284-34-170.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-140, filed 1/4/05, effective 4/1/05.]

WAC 284-34-150 What are the standards for prima facie credit life insurance rates? Subject to WAC 284-34-160 and 284-34-220, the commissioner presumes the prima facie rates shown below meet the requirements of WAC 284-34-140. An insurer may use these rates without filing additional actuarial support.

(1) Monthly outstanding balance basis:

(a) Outstanding insured debt:

(i) Single life: Sixty cents per month per one thousand dollars of outstanding insured debt.

(ii) Joint life: Ninety-six cents per month per one thousand dollars of outstanding insured debt.

(b) Age or age bracket basis: The actuarial equivalent of 1/12 the annual mortality rate for male lives according to commissioner's 1980 standard ordinary mortality table. These conditions apply to the coverage:

(i) The insurer must define the rated age of the debtor in the individual policy or group certificate of insurance;

(ii) The mortality table must be on the same age basis as the coverage;

(iii) If premiums change according to the attained age of the debtor and increase on the debtor's birthday, the mortality table must be on the age near birthday basis;

(iv) The insurer must show the premiums or premium rates for the entire term of coverage in the individual policy or group certificate of insurance; and

(v) All rate changes must be approved by the commissioner.

(2) Single premium basis: If an insurer charges premium on a single premium basis, the rates must be computed by using:

(a) The following formula; or

(b) An alternative formula approved by the commissioner. The alternative formula must produce rates that are equivalent to those produced by the following formula:

$$S_p = \sum_{t=1}^n (O_p/10) \times (I_t/I_1)$$

S_p = Single premium per one hundred dollars of initial insured net debt.

O_p = Sixty cents or ninety-six cents, the prima facie life insurance premium rate per one thousand dollars for monthly outstanding balance coverage from subsection (1) of this section.

I_t = The scheduled amount of insurance for month t.

I_1 = Initial amount of insurance. For a net insurance policy, I_1 equals the initial principal balance of the loan.

n = The number of months in the term of the insurance.

(3) If an insurer provides benefits that are different than those described in this section, premium rates for those benefits must be actuarially consistent with rates in this section.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-150, filed 1/4/05, effective 4/1/05.]

WAC 284-34-160 What mandatory benefits apply to prima facie credit life insurance rates? The premium rates in WAC 284-34-150 apply to credit life insurance contracts that contain terms as favorable to insured debtors as the terms below:

(1) Suicide:

(a) An insurer may exclude coverage for suicide occurring within one year after the effective date of the coverage.

(b) Open-ended credit transactions: An insurer may apply a new suicide exclusion period to the portion of a new advance or charge that causes the amount of credit life insur-

ance to exceed the greatest amount previously subject to this exclusion.

(2) Insurers may elect to include age restrictions in their certificates or policies, subject to the following conditions:

(a) An age restriction may say that no insurance will become effective on debtors who are age sixty-six or older.

(b) An age restriction may say that all insurance will end when the debtor becomes age sixty-six.

(c) Insurance coverage must continue until the end of the period for which a premium payment or charge is made.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34-110. 05-02-076 (Matter No. R 2002-02), § 284-34-160, filed 1/4/05, effective 4/1/05.]

WAC 284-34-170 What are the standards for credit accident and health insurance rates? (1) Subject to WAC 284-34-180 and 284-34-220, the commissioner presumes the prima facie rates shown below meet the requirements of WAC 284-34-140. An insurer may use these rates without filing additional actuarial support.

(a) Single-premium basis for the entire period of debt: The prima facie rate per one hundred dollars of initial insured debt is shown in the table below. Rates for monthly periods other than those listed must be interpolated:

No. of Months	Nonretroactive Benefits		Retroactive Benefits		
	14-day	30-day	7-day	14-day	30-day
1	0.08	0.00	0.27	0.21	0.00
3	0.49	0.18	0.71	0.66	0.47
6	0.95	0.47	1.16	1.12	0.87
12	1.49	0.86	1.85	1.77	1.39
18	1.83	1.13	2.38	2.26	1.76
24	2.07	1.35	2.81	2.65	2.04
30	2.25	1.52	3.17	2.97	2.28
36	2.41	1.67	3.48	3.25	2.48
48	2.65	1.90	3.98	3.69	2.80
60	2.83	2.09	4.38	4.05	3.05
72	2.97	2.24	4.66	4.33	3.25
84	3.09	2.37	4.87	4.57	3.42
96	3.18	2.47	5.04	4.77	3.56
108	3.26	2.56	5.17	4.93	3.68
120	3.32	2.63	5.26	5.07	3.77

(b) Monthly outstanding balance basis for closed-end debt: Insurers must compute premiums according to:

(i) A formula approved by the commissioner that produces rates actuarially consistent with the single premium rates in (a) of this subsection; or

(ii) This formula:

$$OP_n = 10 SP_n \times n / (\sum_{t=1}^n a_{n-t+1})$$

where $a_t = (1 - 1/(1 + i)^t)/i$.

SP_n = Single premium rate per one hundred dollars of initial insured debt repayable in n equal monthly installments as shown in (a) of this subsection.

OP_n = Monthly outstanding balance premium rate per one thousand dollars.

n = The number of months in the term of the insurance.

i = The monthly loan interest rate.

(c) Insurers must calculate single premium rates using the actuarial equivalent of (a) of this subsection.

(i) If an insurer provides coverage for constant maximum indemnity for a given period of time, the commissioner presumes premiums based on the rates in (a) of this subsection are earned according to the rule of anticipation.

(ii) The insurer may estimate the portion of the single premium earned in the first month of coverage by the average of the pro rata earned premium and the "sum of the digits" (also called the "Rule of 78") earned premium.

(iii) If an insurer provides critical period coverage with a benefit period of at least twelve months or the remaining term of the loan:

(A) The rates must be actuarially consistent with the rates for full term benefits in (a) of this subsection.

(B) To ensure actuarial consistency, the insurer may calculate conversion ratios based on the 1974 basic tables of credit A&H claim costs published in the NAIC Proceedings—1975 Vol. I, pages 675-691, or other suitable morbidity table.

(d) Lump sum disability coverage:

(i) The commissioner presumes the monthly premium charges per one hundred dollars of insured balance shown below meet the requirements of WAC 284-34-140. An insurer may use these rates without filing additional actuarial support:

(A) For a ninety-day qualifying period, fifteen cents; and

(B) For a one hundred eighty-day qualifying period, nine cents.

(ii) The insurer must provide a benefit equal to the insured balance on the date of disability. The insurer must return disability premium charges to the debtor for months following the billing month when the disability occurred.

(iii) The insurer may provide lump sum benefits on a single premium basis using the credit life insurance formula in WAC 284-34-150(2) and the rates in (d)(i) of this subsection in place of $O_p/10$.

(2) If insurance is written on open-end credit, the commissioner presumes that the prima facie rates for credit accident and health insurance shown below meet the requirements of WAC 284-34-140.

(a) Open-end credit rates must comply with WAC 284-34-170(3) and 284-34-220. An insurer may use these prima facie rates and the formulae used to calculate them without filing additional actuarial support.

(b) If approved by the commissioner, the insurer may use other formulae to convert rates from a single premium basis to a monthly outstanding balance basis.

(c) If the maximum benefit of the insurance equals the net debt on the date of disability, the term of the loan is calculated according to the formula: $1/(\text{benefit percent})$. The prima facie rate applied to the insured net debt is the portion of the single premium rate earned in the first month of coverage during the calculated term.

(d) If the maximum insurance benefit equals the outstanding balance of the loan on the date of disability plus any interest accruing on that amount during disability, the term of the insurance (n) is estimated by using the following formula:

$$n = \ln \{ 1 - (1000i/x) \} / \ln(v)$$

where:

i = Interest rate on the account or the lowest interest rate in the range used for the class of loan;

x = Monthly payment per one thousand dollars of coverage consistent with the term calculated above; and

$$v = 1/(1 + i).$$

(e) The calculated value of the term is used to look up a single premium rate in WAC 284-34-170 (1)(a). The insurer must calculate the prima facie rate applied to the insured net debt by multiplying the portion of the single premium rate earned in the first month of coverage by:

The adjustment n/a_n

Where:

n is the term calculated above, not to exceed forty-eight months; and

$$a_n = (1 - v^n)/i.$$

(f) An insurer may use the following monthly premium rates per one thousand dollars of insured net debt as composite rates for the following minimum benefit plans:

(i) Fourteen-day nonretroactive plan: \$1.06

(ii) Thirty-day nonretroactive plan: \$0.81

(iii) Seven-day retroactive plan: \$1.72

(iv) Fourteen-day retroactive plan: \$1.58

(v) Thirty-day retroactive plan: \$1.18

The insurer must state the monthly benefit in the certificate of insurance as a percentage of the insured net debt. The insurer must provide a monthly benefit sufficient to pay off the insured debt, including accruing interest, within forty-eight months.

(3) If an insurer sells accident and health coverage on a joint basis (insuring two debtors on the same loan), the joint coverage rate must be computed by multiplying the corresponding single coverage rate by 1.6.

(4) If an insurer provides benefits that are different than those described in this section, premium rates for those benefits must be actuarially consistent with rates in this section.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-170, filed 1/4/05, effective 4/1/05.]

WAC 284-34-180 What mandatory benefits apply to prima facie credit accident and health insurance rates? The premium rates in WAC 284-34-170 apply to contracts providing credit accident and health insurance that contain terms as favorable to insured debtors as the terms below:

(1) The insurer may exclude benefits for disabilities that result from the following:

(a) War or any act of war;

(b) Elective surgery;

(c) Intentionally self-inflicted injury;

(d) Flight in any aircraft other than a commercial scheduled aircraft;

(e) A preexisting condition. The preexisting condition exclusion does not apply to disabilities that begin at least six months after the effective date.

(2) Open-ended credit transaction: An insurer may apply a preexisting condition exclusion only to the portion of a new advance or charge that causes the amount of credit accident

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and health insurance to exceed the greatest amount previously subject to this exclusion.

(3) Definition of disability:

(a) For the first twenty-four months of disability: Total disability means the inability to perform the essential functions of the debtor's own occupation.

(b) After the first twenty-four months: Disability means the inability of the insured to perform the essential functions of any occupation for which the debtor is reasonably suited due to education, training or experience.

(4) An insurer may require a statement that the debtor is actively at work before insurance becomes effective.

(a) The insurer may not require the insured debtor to be employed more than thirty hours per week.

(b) If a debtor is absent due to a regular day off, holiday or paid vacation, the commissioner presumes the debtor is actively at work.

(5) Insurers may elect to include age restrictions in their certificates or policies, subject to the following conditions:

(a) An age restriction may say that no insurance will become effective on debtors who are age sixty-six or older.

(b) An age restriction may say that all insurance will end when the debtor becomes age sixty-six.

(c) Insurance coverage must continue until the end of the period for which a premium payment or charge is made.

(6) The insurer must provide a daily benefit equal to or greater than one-thirtieth of the monthly benefit payable under the policy.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-180, filed 1/4/05, effective 4/1/05.]

WAC 284-34-190 What refund formulas are allowed? (1) The commissioner must approve refund formulas before they are used. The insurer must state the basis for the refund in the policy or certificate delivered to the debtor. The following methods, or other methods approved by the commissioner must be used:

(a) Pro rata method. The pro rata unearned gross premium method must be used for:

(i) Level term credit life insurance;

(ii) Credit accident and health insurance if the insured is covered for a constant maximum indemnity; and

(iii) All credit insurance where the debtor is not charged on the single premium basis.

(b) Rule of anticipation. Unless the coverage is listed in (a) of this subsection, the refund must be at least what would have been charged for the remaining coverage for the remaining term of debt. An insurer may file other methods if they generate equivalent results.

(2) If coverage ends:

(a) The insurer may not charge insurance premium for the first fifteen days of a month.

(b) The insurer may charge premium for a full month if the debtor is covered for sixteen days or more.

(3) No refund of five dollars or less need be made.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-190, filed 1/4/05, effective 4/1/05.]

WAC 284-34-200 Do insurers have to file experience reports? Each authorized insurer in this state must file an annual report of consumer credit insurance written on a calendar year basis. The insurer must file the report with the commissioner and the National Association of Insurance Commissioners (NAIC). The report must:

- (1) Use the Credit Insurance Supplement - Annual Statement Blank approved by the NAIC;
- (2) Contain data separately for each state. An insurer may not use an allocation of its country-wide experience; and
- (3) Be filed by the due date in the instructions to the annual statement.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34-110. 05-02-076 (Matter No. R 2002-02), § 284-34-200, filed 1/4/05, effective 4/1/05.]

WAC 284-34-210 When will the commissioner adjust prima facie rates, and how will rate changes be implemented? (1) Every three years, the commissioner will review the loss ratio standards in WAC 284-34-140 and the prima facie rates in WAC 284-34-150 and 284-34-170 to:

- (a) Determine the rate of expected claims on a statewide basis;
 - (b) Compare the rate of expected claims with the rate of actual claims for the preceding three years using data reported in the annual statement supplement or other available source(s);
 - (c) Determine if new rates should be published based on the rate of expected claims; and
 - (d) If needed, publish new statewide prima facie rates, and establish a date when all insurers must file new rates.
- (2) When the commissioner publishes new rates, they will reflect:
- (a) The difference between actual claims based on experience; and
 - (b) Expected claims based on the loss ratio standards in WAC 284-34-140 applied to the prima facie rates in WAC 284-34-150 and 284-34-170.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34-110. 05-02-076 (Matter No. R 2002-02), § 284-34-210, filed 1/4/05, effective 4/1/05.]

WAC 284-34-220 What rates may an insurer use for its direct business? (1) An insurer may file rates that are equivalent to the prima facie rates in WAC 284-34-150 and 284-34-170 and use those rates without further proof of their reasonableness.

- (2) An insurer must file rates and supporting actuarial documentation if it proposes:
 - (a) Policy provisions more restrictive than those allowed for prima facie rates; or
 - (b) Rates higher than those developed according to the standard case rating procedure.
- (3) An insurer must file rates in a manner that permits public disclosure of the rates and their application as described in a supporting actuarial memorandum. If an insurer wants the commissioner to withhold experience and proprietary rate development methods from public disclosure to preserve trade secrets or prevent unfair competition, the insurer must:

(a) File that information in a separate actuarial memorandum; and

(b) Clearly identify the information that is confidential.

(4) Any filings that do not include all data and calculations required by this section will be disapproved and returned to the insurer.

(5) An insurer may file rates that are higher than the prima facie rates included in WAC 284-34-150 and 284-34-170. The rates must be adjusted under WAC 284-34-210 and result in benefits that are reasonable in relation to the premium charged. When evaluating deviations, the commissioner will:

(a) Evaluate the insurer's total consumer credit insurance business, including insurance written by affiliated insurers, for each type of consumer credit insurance for which a rate deviation is being filed.

(b) Consider whether the insurer can be reasonably expected to develop a sixty percent loss ratio.

(c) Evaluate the actuarial justification to see if it proves that the benefits will be reasonable in relation to premium charged. The insurer must submit actuarial justification that includes:

(i) All calculations and supporting data required for the standard case rating procedure set forth in WAC 284-34-220(10). The insurer must show the loss ratio the rates are expected to develop.

(ii) An actuarial memorandum that:

(A) Explains the calculations of all elements affecting earned premiums or incurred claims; and

(B) Projects experience from inception to equilibrium or termination.

(6) The insurer must specify the account or accounts to which the deviated rates apply.

(7) A deviated rate may be applied:

(a) Uniformly to all accounts of the insurer;

(b) Equitably to only one or more accounts of the insurer for which the experience has been less favorable than expected; or

(c) According to a case-rating procedure approved by the commissioner. The insurer must compare the rates developed by the proposed case-rating procedure to the rates developed by the standard case-rating procedure set forth in WAC 284-34-220(10).

(8) A deviated rate may be in effect for a period no longer than the experience period used to establish the rate (i.e., one-year, two-years or three-years). An insurer may file a new rate before the end of a rate period, but no more than once during any twelve-month period.

(9) A deviated rate may be used only by the insurer that filed the rate. If an account changes insurers, the rates approved for the prior insurer may not be used by the succeeding insurer.

(10) Standard case rating procedure. An insurer may file rates calculated using this standard case rating procedure. If an insurer decides to use this procedure, the insurer must use it to rate all of its credit insurance in this state. Once an insurer selects this procedure, the insurer must continue to use it until a different procedure has been approved by the commissioner.

(a) Account case rate. The case rate for an account is determined as follows:

(i) If the account is a single account case or a multiple account case, the case rate must be determined by the formula in (b) of this subsection.

(ii) If the account is in a pooled account case, the case rate for each account must be determined by the formula set forth in (b) of this subsection.

(iii) If the account is new and the insurer has no experience in this state, the case rate for the account will be the prima facie rate under WAC 284-34-150 and 284-34-170.

(b) New case rate. The new case rate, NCR, is the sum of:

(i) The adjusted expense loading, AE; and

(ii) The prima facie rate, PFR, times the credibility adjusted case loss ratio at prima facie basis, CLR.

(iii) Formula: $NCR = AE + PFR \times CLR$.

(c) Definitions:

(i) NCR is equivalently redefined in (d) of this subsection.

(ii) ALR is the actual loss ratio for the case at prima facie rates.

(iii) ELR is the minimum loss ratio, equal to sixty percent.

(iv) Z is the credibility factor for the case.

(v) CLR is the sum of Z times ALR and (1-Z) times ELR.

(vi) E is the expense loading in the prima facie rate, equal to forty percent of the prima facie rate.

(d) Formulas:

(i) If CLR is less than ELR for credit life insurance or credit accident and health insurance, then $AE = E$, and $NCR = PFR[1 - (ELR - CLR)]$.

(ii) If CLR is greater than ELR for credit life insurance, $AE = E + .1(CLR - ELR)$, and $NCR = PFR[1 + 1.1(CLR - ELR)]$.

(iii) If CLR is greater than ELR for credit accident and health insurance, $AE = E + .2(CLR - ELR)$, and $NCR = PFR[1 + 1.2(CLR - ELR)]$.

(e) The new case rate will be the current case rate if the new case rate, as defined above, does not differ by more than five percent of the prima facie rate from the current case rate.

(f) If an insurer has filed deviated rates or has elected to use the standard case rating procedure, the insurer must file a new schedule of rates after it submits the credit insurance experience exhibit.

(i) This filing must include an actuarial memorandum that proves the new rates are appropriate and explains any differences in the character of the claim reserves and liabilities as reported in its:

(A) Exhibit 6 (claim reserves) and Exhibit 8 (claim liabilities) of its annual statement;

(B) Credit insurance experience exhibits for this state; and

(C) Experience as filed for the total of the cases subject to the rate filing.

(ii) The new rates must be placed in effect on September 1 of that year unless:

(A) The commissioner approves a different effective date; or

(B) The commissioner disapproves the rates within thirty days after receipt of the filing or by July 1 of that year, whichever is later.

(11) An insurer may file lower rates at any time. The commissioner must approve those rates before they are used.

(12) These definitions apply to this section:

(a) "**Case**" includes either a "**single account case**" or a "**multiple account case**" or a "**pooled account case**."

(i) "**Single account case**" means an account that is at least as credible as the minimum level of credibility elected by the insurer for defining a single account case. A single account case must exclude all accounts which have been included in multiple account cases. If the insurer makes no written election, the minimum credibility factor will be one hundred percent.

(ii) "**Multiple account case**" means two or more accounts of the same insurer having similar underwriting characteristics that are combined by the insurer for premium rating purposes.

(A) A single account case may not be included in a multiple account case; and

(B) All accounts, when combined, must be at least as credible as the minimum level of credibility the insurer selects for single account cases; and

(C) The commissioner must approve the accounts put into a multiple case account.

(iii) "**Pooled account case**" means a combination of all the insurer's accounts of the same plan of insurance. The pooled account case must have experience in this state and exclude all single account cases and multiple account cases.

(b) "**Earned premium**" means the total gross premiums that become due to the insurer adjusted for the change in unearned premium reserve. The insurer may reduce earned premium only for refunds and adjustments due to termination of coverage. The unearned premium reserve is calculated according to the refund formula in WAC 284-34-190.

(c) "**Experience**" means:

(i) Written premiums;

(ii) Earned premiums;

(iii) Earned premiums at prima facie rates;

(iv) Paid claims;

(v) Incurred claims;

(vi) Incurred claim count; and

(vii) The number of life years insured during the experience period.

(d) "**Experience period**" means the most recent period of time for which experience is reported. The experience period may not exceed three full years.

(e) "**Incurred claims**" means total claims paid during the experience period adjusted for the change in claim reserves and liabilities.

(i) The commissioner considers a disability claim incurred on the date disability commenced.

(ii) The commissioner may disallow that part of any claim reserve or liability that cannot be supported by verifiable data.

(f) "**Incurred claim count**" means the number of claims incurred for the case during the experience period. An incurred claim count includes:

(i) The total number of claims reported during the experience period, whether paid or in the process of payment.

(ii) Any incurred but not reported (IBNR) at the end of the experience period less the number of IBNR claims at the beginning of the experience period.

(iii) If a debtor has been issued more than one certificate for the same plan of insurance, only one claim may be counted.

(iv) If a debtor receives disability benefits, only the initial claim payment for that period of disability may be counted.

(h) "**Credibility table**" for purposes of the standard case rating procedure means the following table:

Credit Life	Credit Accident and Health Plans Retroactive and Nonretroactive			Incurred Claim Count	Credibility Factor
	7-day	14-day	30-day		
1	1	1	1	1	0.00
1,800	95	141	209	9	0.25
2,400	126	188	279	12	0.30
3,000	158	234	349	15	0.35
3,600	189	281	419	18	0.40
4,600	242	359	535	23	0.45
5,600	295	438	651	28	0.50
6,600	347	516	767	33	0.55
7,600	400	594	884	38	0.60
9,600	505	750	1,116	48	0.65
11,600	611	906	1,349	58	0.70
14,600	768	1,141	1,698	73	0.75
17,600	926	1,375	2,047	88	0.80
20,600	1,084	1,609	2,395	103	0.85
25,600	1,347	2,000	2,977	128	0.90
30,600	1,611	2,391	3,558	153	0.95
40,000	2,106	3,125	4,651	200	1.00

(i) The integral numbers above represent the lower end of the bracket for each credibility factor "Z." The upper end is one less than the lower end for the next higher Z factor.

(ii) To use this table, find the credibility factor from the credibility table for the experience group.

(iii) If actual loss ratios are less than fifty percent, use the average number of life years for both life insurance and disability insurance. Otherwise, use either the average number of life years or the incurred claims count.

If either of these measures cannot be accurately determined, the commissioner may accept reasonable approximations.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-220, filed 1/4/05, effective 4/1/05.]

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

WAC 284-34-230 What obligations does an insurer have to supervise consumer credit operations? Each insurer transacting credit insurance in this state must:

(1) Periodically conduct a complete review of creditors. This review must include all aspects of the credit insurance business and assure compliance with all state insurance laws and regulations.

(2) Maintain written records of the reviews for examination by the commissioner for at least three years.

(3) Maintain a list of all licensed individuals who have sold or been compensated for the sale of consumer credit insurance. This list must show a licensed individual for each consumer credit insurance policy or certificate issued.

(g) "**Average number of life years**" means the average number of group certificates or individual policies in force during the experience period (without regard to multiple coverage) times the number of years in the experience period, or an equivalent calculation.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-230, filed 1/4/05, effective 4/1/05.]

WAC 284-34-240 What practices are insurers prohibited from doing? The following practices, when engaged in by insurers in connection with the sale or placement of credit insurance, or as an inducement thereto, constitute unfair methods of competition and are subject to the enforcement provisions of RCW 48.30.010. An insurer must not:

(1) Offer or grant to a creditor any special advantage or service that is not included in either the group insurance contract or in the agency contract. This subsection does not prohibit payment of agent's commissions.

(2) Agree to deposit with a bank or financial institution money or securities of the insurer with the design or intent that the deposit will affect or replace a deposit of money or securities that otherwise would be required of the creditor by the bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement.

(3) Deposit money or securities without interest or at a lesser rate of interest than is currently being paid by the creditor, bank or financial institution to other depositors of like amounts for similar durations. This subsection does not prohibit an insurer from maintaining demand deposits or premium deposit accounts that the insurer needs to use in the ordinary course of the insurer's business.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-240, filed 1/4/05, effective 4/1/05.]

WAC 284-34-250 What information must be disclosed to debtors? (1) If a debtor buys consumer credit

insurance in connection with a credit transaction, the creditor must disclose this information to the debtor in writing:

(a) The debtor does not have to buy consumer credit insurance.

(b) The debtor may not need consumer credit insurance if the debtor has other insurance that covers the risk.

(c) The debtor does not have to buy consumer credit insurance to obtain credit approval.

(d) If the creditor offers more than one type of consumer credit insurance to debtors, whether the debtor can buy each type of insurance separately.

(e) The insurer may decide to deny coverage. This statement must list all factors that may cause the insurer to deny or limit coverage, including:

- (i) Underwriting standards;
- (ii) Exceptions to coverage;
- (iii) Limitations and exclusions to coverage;
- (iv) Eligibility criteria; and
- (v) The date coverage will be effective.

(f) The debtor can cancel coverage within the first thirty days after receiving an individual policy or group certificate. The insurer or creditor must promptly refund or credit to the debtor's account all amounts charged for insurance or obtaining it.

(g) The debtor may cancel coverage at any time during the term of the loan if the:

- (i) Debtor buys other insurance that covers the risk; or
- (ii) Credit agreement does not require the debtor to buy consumer credit insurance.

(h) If the debtor cancels coverage, the insurer or creditor must promptly pay or credit to the debtor's account a refund of all unearned premium.

(i) That the debtor must provide evidence of alternative insurance acceptable to the creditor at the time of cancellation only if insurance is a requirement for the extension of credit.

(j) A brief description of the coverage, including a description of:

- (i) The amount of insurance;
- (ii) The term of insurance;
- (iii) Insured events;
- (iv) Any waiting or elimination period;
- (v) Any applicable waiver of premium provision;
- (vi) To whom the benefits would be paid; and
- (vii) The rate for each type of coverage.

(k) If the premium or insurance charge(s) are financed, they are subject to finance charges at the rate applicable to the credit transaction.

(2) An individual policy or group certificate must, in addition to other requirements of RCW 48.34.090, state the following:

(a) Closed-end credit: The premium or amount of payment by the debtor separately for each kind of coverage.

(b) Open-end credit: The premium rate and the basis of premium calculation (e.g., average daily balance, prior monthly balance).

(c) If the scheduled term of insurance is less than the scheduled term of the credit transaction, the face of each individual policy or group certificate must display a prominent notice explaining that the insurance coverage will end before the loan ends.

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(d) Each individual policy or group certificate must display a prominent notice of any exceptions, restrictions, limitations or exclusions.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-250, filed 1/4/05, effective 4/1/05.]

WAC 284-34-260 What is the effective date of this regulation? (1) This regulation takes effect on April 1, 2005.

(2) Approval of all forms that do not comply with this regulation is withdrawn as of October 1, 2005. No form may be issued on or after October 1, 2005, unless it has been approved by the commissioner and conforms to this regulation.

(3) Group insurance:

(a) Certificates and premium rates used with existing policies must conform to this regulation by the first anniversary date of the policy on or after October 1, 2005. This includes, but is not limited to:

(i) Continuing insurance on a debtor where agreement between the insurer and the group policyholder, with or without notice to the debtor, is sufficient to terminate that insurance; and

(ii) Continuing insurance on a debtor where the insurer has the right to change premium rates with the approval of the commissioner.

(b) For the purpose of this subsection, no new form or policy that amends or replaces an existing policy of consumer credit insurance may alter the anniversary date of the policy.

(c) "Existing policy" means a policy in force prior to October 1, 2005.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.34.100, and 48.34.-110. 05-02-076 (Matter No. R 2002-02), § 284-34-260, filed 1/4/05, effective 4/1/05.]

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

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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 284-36A WAC FRATERNAL BENEFIT SOCIETIES

WAC

284-36A-005	Purpose and scope.
284-36A-010	Definitions.
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284-36A-035	Confidentiality of RBS reports—Use of information for comparative purposes—Use of information to monitor solvency.
284-36A-040	Society action level event.
284-36A-045	Regulatory action level event.
284-36A-050	Authorized control level event.
284-36A-055	Mandatory control level event.
284-36A-060	Fraternal benefit society's right to a hearing.
284-36A-065	RBS report from foreign fraternal benefit society.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-36A-025	Risk-based surplus (RBS) financial standard formula. [Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-025, filed 4/6/98, effective 5/7/98. Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.-290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.-286, 48.36A.290, 48.36A.310 and 1996 c 236. 96-22-064 (Matter No. R 96-5), § 284-36A-025, filed 11/4/96, effective 12/5/96.] Repealed by 99-01-142 (Matter R 98-19), filed 12/22/98, effective 1/22/99. Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290.
284-36A-030	RBS level—Commissioner's action. [Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.286, 48.36A.290, 48.36A.310 and 1996 c 236. 96-22-064, § 284-36A-030 (Matter No. R 96-5), filed 11/4/96, effective 12/5/96.] Repealed by 98-09-016 (Matter R 98-03), filed 4/6/98, effective 5/7/98. Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290.

WAC 284-36A-005 Purpose and scope. This chapter applies to all fraternal benefit societies transacting the business of life and disability insurance in this state. The risk-based surplus standard in this chapter provide a mechanism for the commissioner to evaluate the ability of a fraternal ben-

efit society to manage its insurance operations and to fulfill its responsibilities as tax-exempt benevolent and charitable organization for the benefit of members and others. The risk-based surplus standard of this chapter is a minimum standard. It is an estimate of the surplus level required of a fraternal benefit society that is necessary so that the entity may survive a series of catastrophic financial events. The risk-based surplus formula is the ratio of the fraternal benefit society's total adjusted surplus to its risk-based surplus.

[Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.286, 48.36A.290, 48.36A.-310 and 1996 c 236. 96-22-064 (Matter No. R 96-5), § 284-36A-005, filed 11/4/96, effective 12/5/96.]

WAC 284-36A-010 Definitions. (1) "Adjusted RBS report" means an RBS report which has been adjusted by the commissioner in accordance with WAC 284-36A-020(4).

(2) "AVR" means asset valuation reserve.

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

(4) "Fraternal benefit society" is defined at RCW 48.36A.010.

(5) "NAIC" means the National Association of Insurance Commissioners.

(6) "Negative trend" means, with respect to a fraternal benefit society, negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBS instructions.

(7) "RBC" means risk-based capital.

(8) "RBS" means risk-based surplus.

(9) "RBS instructions" means the RBC report for life insurance companies, including risk-based capital instructions adopted, by the NAIC.

(10) "RBS level" means a fraternal benefit society's society action level RBS, regulatory action level RBS, authorized control level RBS, or mandatory control level RBS where:

(a) "Society action level RBS" means, with respect to a fraternal benefit society, the product of 2.0 and its authorized control level RBS;

(b) "Regulatory action level RBS" means the product of 1.5 and its authorized control level RBS;

(c) "Authorized control level RBS" means the number determined under the risk-based surplus formula in accordance with the RBS instructions;

(d) "Mandatory control level RBS" means the product of .70 and the authorized control level RBS.

(11) "RBS plan" means a comprehensive financial plan containing the elements specified in WAC 284-36A-040(2). If the commissioner rejects the RBS plan, and it is revised by the fraternal benefit society, with or without the commissioner's recommendation, the plan shall be called the "revised RBS plan."

(12) "RBS report" means the report required in WAC 284-36A-050 and 284-36A-020.

(13) "Total adjusted surplus" means the sum of:

(a) A fraternal benefit society's statutory surplus as determined in accordance with statutory accounting applicable to the annual financial statement required to be filed under RCW 48.36A.260; and

(b) Other items, if any, as the RBS instructions may provide.

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 99-01-142 (Matter R 98-19), § 284-36A-010, filed 12/22/98, effective 1/22/99; 98-09-016 (Matter R 98-03), § 284-36A-010, filed 4/6/98, effective 5/7/98. Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.286, 48.36A.290, 48.36A.310 and 1996 c 236. 96-22-064 (Matter No. R 96-5), § 284-36A-010, filed 11/4/96, effective 12/5/96.]

WAC 284-36A-020 Report of RBS level—Formula for determining level—Inaccurate reports adjusted by commissioner. (1) On or prior to the annual filing date, which is hereby established as March 1, every fraternal benefit society authorized to transact insurance business in this state, shall prepare and submit to the commissioner a report of its RBS level as of the end of the calendar year just ended, in a form and containing all information required by the RBS instructions.

(2) The RBS of a fraternal benefit society shall be determined in accordance with the formula set forth in the RBS instructions. The formula shall take into account and may adjust for the covariance between:

(a) The risk with respect to the assets of the fraternal benefit society;

(b) The risk of adverse insurance experience with respect to the liabilities and obligations of the fraternal benefit society;

(c) The interest rate risk with respect to the business of the fraternal benefit society; and

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

(3) An excess of surplus over the amount produced by the RBS requirements and the formulas, schedules, and instructions under this chapter is desirable in the insurance business of fraternal benefit societies. Accordingly, fraternal benefit societies should seek to maintain unimpaired surplus above the RBS level required. Additional unimpaired surplus is used and useful in the insurance business of fraternal benefit societies and helps to secure a fraternal benefit society against various risks inherent in, or affecting, the insurance business of fraternal benefit societies and not accounted for or only partially measured by the RBS requirements.

(4) If a fraternal benefit society files an RBS report that in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBS report to correct the inaccuracy and shall notify the fraternal benefit society of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBS report as so adjusted is referred to as an "adjusted RBS report."

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 99-01-142 (Matter R 98-19), § 284-36A-020, filed 12/22/98, effective 1/22/99; 98-09-016 (Matter R 98-03), § 284-36A-020, filed 4/6/98, effective 5/7/98. Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.286, 48.36A.290, 48.36A.310 and 1996 c 236. 96-22-064 (Matter No. R 96-5), § 284-36A-020, filed 11/4/96, effective 12/5/96.]

WAC 284-36A-035 Confidentiality of RBS reports—Use of information for comparative purposes—Use of information to monitor solvency. (1) All RBS reports, to

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the extent the information is not required to be set forth in a publicly available annual statement schedule, including the results or report of any examination or analysis of a fraternal benefit society that are filed with the commissioner constitute information that might be damaging to the fraternal benefit society 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.

(2) The comparison of a fraternal benefit society's total adjusted surplus to its RBS level is a regulatory tool that may indicate the need for possible corrective action with respect to the fraternal benefit society, and is not a means to rank fraternal benefit societies generally. Therefore, except as otherwise required under the provisions of this chapter, 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 RBS level of any fraternal benefit society, or of any component derived in the calculation, by any fraternal benefit society, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the comparison regarding a fraternal benefit society's total adjusted surplus to its RBS level or an inappropriate comparison of any other amount to the fraternal benefit society's RBS level is published in any written publication and the fraternal benefit society 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 fraternal benefit society may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) The RBS instructions and RBS reports are solely for use by the commissioner in monitoring the solvency of fraternal benefit societies and the need for possible corrective action with respect to fraternal benefit societies and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a fraternal benefit society or any affiliate is authorized to write.

[Statutory Authority: RCW 48.02.060, 48.36A.100(7), 48.36A.290(4), 48.36A.100, 48.36A.282, 48.36A.284, 48.36A.286, 48.36A.290, 48.36A.310 and 1996 c 236. 96-22-064 (Matter No. R 96-5), § 284-36A-035, filed 11/4/96, effective 12/5/96.]

WAC 284-36A-040 Society action level event. (1) "Society action level event" means any of the following events:

(a) The filing of an RBS report by a fraternal benefit society which indicates that the fraternal benefit society's has total adjusted surplus which is greater than or equal to its society action level RBS but less than the product of its

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authorized control level RBS and 2.5 and has a negative trend;

(b) The notification by the commissioner to the fraternal benefit society of an adjusted RBS report that indicates an event in (a) of this subsection, provided the insurer does not challenge the adjusted RBS report under WAC 284-36A-060; or

(c) If, pursuant to WAC 284-36A-060, a fraternal benefit society challenges an adjusted RBS report that indicates the event in (a) of this subsection, the notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge.

(2) In the event of a society action level event, the fraternal benefit society shall prepare and submit to the commissioner an RBS plan which shall:

(a) Identify the conditions which contribute to the society action level event;

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

(c) Provide projections of the fraternal benefit society'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 operating income, net income, and surplus. (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 fraternal benefit society's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the fraternal benefit society'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, if any, in each case.

(3) The RBS plan shall be submitted:

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

(b) If the fraternal benefit society challenges an adjusted RBS report pursuant to WAC 284-36A-060, within forty-five days after notification to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge.

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

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

(b) If the fraternal benefit society challenges the notification from the commissioner under WAC 284-36A-060, within forty-five days after a notification to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge.

(5) In the event of a notification by the commissioner to a fraternal benefit society that the fraternal benefit society's RBS plan or revised RBS plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the fraternal benefit society's rights to a hearing under WAC 284-36A-060, specify in the notification that the notification constitutes a regulatory action level event.

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

(a) Such state has an RBS provision substantially similar to WAC 284-36A-035(1); and

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

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

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

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-040, filed 4/6/98, effective 5/7/98.]

WAC 284-36A-045 Regulatory action level event. (1) "Regulatory action level event" means, with respect to a fraternal benefit society, any of the following events:

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

(b) The notification by the commissioner to a fraternal benefit society of an adjusted RBS report that indicates the event in (a) of this subsection, provided the fraternal benefit society does not challenge the adjusted RBS report under WAC 284-36A-060;

(c) If, pursuant to WAC 284-36A-060, the fraternal benefit society challenges an adjusted RBS report that indicates the event in (a) of this subsection, the notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge;

(d) The failure of the fraternal benefit society to file an RBS report by the filing date, unless the fraternal benefit society 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 fraternal benefit society to submit an RBS plan to the commissioner within the time period set forth in WAC 284-36A-040(3);

(f) Notification by the commissioner to the fraternal benefit society that:

(i) The RBS plan or revised RBS plan submitted by the fraternal benefit society is, in the judgment of the commissioner, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the fraternal benefit society, provided the fraternal benefit society has not challenged the determination under WAC 284-36A-060;

(g) If, pursuant to WAC 284-36A-060, the fraternal benefit society challenges a determination by the commissioner under (f) of this subsection, the notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected such challenge;

(h) Notification by the commissioner to the fraternal benefit society that the fraternal benefit society has failed to adhere to its RBS plan or revised RBS plan, but only if such failure has a substantial adverse effect on the ability of the fraternal benefit society to eliminate the society action level event in accordance with its RBS plan or revised RBS plan and the commissioner has so stated in the notification, provided the fraternal benefit society has not challenged the determination under WAC 284-36A-060; or

(i) If, pursuant to WAC 284-36A-060, the fraternal benefit society challenges a determination by the commissioner under (h) of this subsection, the notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected the challenge.

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

(a) Require the fraternal benefit society to prepare and submit an RBS plan or, if applicable, a revised RBS plan;

(b) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the fraternal benefit society including a review of its RBS plan or revised RBS 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 fraternal benefit society based upon the commissioner's examination or analysis of the assets, liabilities and operations of the fraternal benefit society, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBS instructions. The RBS plan or revised RBS plan shall be submitted:

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

(b) If the fraternal benefit society challenges an adjusted RBS report pursuant to WAC 284-36A-060 and the challenge is not frivolous in the judgment of the commissioner within forty-five days after the notification to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge; or

(c) If the fraternal benefit society challenges a revised RBS plan pursuant to WAC 284-36A-060 and the challenge is not frivolous in the judgment of the commissioner, within forty-five days after the notification to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society'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 fraternal benefit society's RBS plan or revised RBS plan, examine or analyze the assets, liabilities and operations of the fraternal benefit society and formulate the corrective order with respect to the fraternal benefit society. The fees, costs and expenses relating to consultants shall be borne by the affected fraternal benefit society or such other party as directed by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-045, filed 4/6/98, effective 5/7/98.]

WAC 284-36A-050 Authorized control level event.

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

(a) The filing of an RBS report by the fraternal benefit society which indicates that the fraternal benefit society's total adjusted capital is greater than or equal to its mandatory control level RBS but less than its authorized control level RBS;

(b) The notification by the commissioner to the fraternal benefit society of an adjusted RBS report that indicates the event in (a) of this subsection, provided the fraternal benefit society does not challenge the adjusted RBS report under WAC 284-36A-060;

(c) If, pursuant to WAC 284-36A-060, the fraternal benefit society challenges an adjusted RBS report that indicates the event in (a) of this subsection, notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge;

(d) The failure of the fraternal benefit society to respond, in a manner satisfactory to the commissioner, to a corrective order (provided the fraternal benefit society has not challenged the corrective order under WAC 284-36A-060); or

(e) If the fraternal benefit society has challenged a corrective order under WAC 284-36A-060 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the fraternal benefit society 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 a fraternal benefit society, the commissioner shall:

(a) Take such actions as are required under WAC 284-36A-045 regarding a fraternal benefit society with respect to which a regulatory action level event has occurred; or

(b) If the commissioner deems it to be in the best interests of the policyholders and creditors of the fraternal benefit society and of the public, take such actions as are necessary to cause the fraternal benefit society to be placed under regulatory control under RCW 48.36A.286. 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 RCW 48.36A.286, and the commissioner shall have the rights, powers and duties with respect to the fraternal benefit society as are set forth in chapter 48.31 RCW. In the event the commissioner takes actions under this paragraph pursuant to an adjusted RBS report, the

fraternal benefit society shall be entitled to such protections as are afforded to fraternal benefit societies under the provisions of RCW 48.31.121 pertaining to summary proceedings.

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-050, filed 4/6/98, effective 5/7/98.]

WAC 284-36A-055 Mandatory control level event.

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

(a) The filing of an RBS report which indicates that the fraternal benefit society's total adjusted surplus is less than its mandatory control level RBS;

(b) Notification by the commissioner to the fraternal benefit society of an adjusted RBS report that indicates the event in (a) of this subsection, provided the fraternal benefit society does not challenge the adjusted RBS report under WAC 284-36A-060; or

(c) If, pursuant to WAC 284-36A-060, the fraternal benefit society challenges an adjusted RBS report that indicates the event in (a) of this subsection, notification by the commissioner to the fraternal benefit society that the commissioner has, after a hearing, rejected the fraternal benefit society's challenge.

(2) In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the fraternal benefit society under regulatory control under RCW 48.36A.286. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under RCW 48.36A.286, and the commissioner shall have the rights, powers and duties with respect to the fraternal benefit society as are set forth in chapter 48.31 RCW. If the commissioner takes actions pursuant to an adjusted RBS report, the fraternal benefit society shall be entitled to the protections of RCW 48.31.121 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 the commissioner 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, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-055, filed 4/6/98, effective 5/7/98.]

WAC 284-36A-060 Fraternal benefit society's right to a hearing. (1) Upon notification to a fraternal benefit society by the commissioner of any of the following, the fraternal benefit society shall have the right to a hearing, in accordance with chapters 48.04 and 34.05 RCW, at which the fraternal benefit society may challenge any determination or action by the commissioner:

(a) Of an adjusted RBS report; or

(b)(i) That the fraternal benefit society's RBS plan or revised RBS plan is unsatisfactory; and

(ii) The notification constitutes a regulatory action level event with respect to such fraternal benefit society; or

(c) That the fraternal benefit society has failed to adhere to its RBS plan or revised RBS plan and that such failure has a substantial adverse effect on the ability of the fraternal benefit society to eliminate the society action level event with respect to the fraternal benefit society in accordance with its RBS plan or revised RBS plan; or

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(d) Of a corrective order with respect to the fraternal benefit society.

(2) The fraternal benefit society shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under this section. Upon receipt of the fraternal benefit society's request for a hearing, the commissioner shall set a date for the hearing. The date shall be no less than ten nor more than ninety days after the date of the fraternal benefit society's request.

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-060, filed 4/6/98, effective 5/7/98.]

WAC 284-36A-065 RBS report from foreign fraternal benefit society. (1) In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign fraternal benefit society as determined under the RBS statute applicable in the state of domicile of the fraternal benefit society (or, if no RBS statute is in force in that state, under the provisions of this regulation), if the insurance commissioner of the state of domicile of the foreign fraternal benefit society fails to require the foreign fraternal benefit society to file an RBS plan in the manner specified under that state's RBS statute (or, if no RBS statute is in force in that state, under WAC 284-36A-040), the commissioner may require the foreign or fraternal benefit society to file an RBS plan with the commissioner. In such event, the failure of the foreign fraternal benefit society to file an RBS plan with the commissioner shall be grounds to order the fraternal benefit society to cease and desist from writing new insurance business in this state.

(2) In the event of a mandatory control level event with respect to any foreign fraternal benefit society, if no domiciliary receiver has been appointed with respect to the foreign fraternal benefit society under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign fraternal benefit society, the commissioner may apply for an order pursuant to RCW 48.31.080 to conserve the assets within this state of foreign fraternal benefit society, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

(2) In the event of a mandatory control level event with respect to any foreign fraternal benefit society, if no domiciliary receiver has been appointed with respect to the foreign fraternal benefit society under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign fraternal benefit society, the commissioner may apply for an order pursuant to RCW 48.31.080 to conserve the assets within this state of foreign fraternal benefit society, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

[Statutory Authority: RCW 48.02.060, 48.36A.100 and 48.36A.290. 98-09-016 (Matter R 98-03), § 284-36A-065, filed 4/6/98, effective 5/7/98.]

Chapter 284-37 WAC

MARKET CONDUCT OVERSIGHT PROGRAM

WAC

284-37-010	Definitions.
284-37-020	Procedures manuals.
284-37-030	Access to records.
284-37-040	Market conduct annual statement.
284-37-050	Complaint verification.
284-37-060	Dispute resolution.

WAC 284-37-010 Definitions. The following definitions apply throughout this chapter unless the context requires otherwise:

(1) "Insurer" shall have the same meaning as set forth in chapter 82, section 5(4), Laws of 2007, and specifically includes health care service contractors, health maintenance organizations, fraternal benefit societies, and self-funded multiple employer welfare arrangements.

(2009 Ed.)

(2) "Insurance" shall have the same meaning as set forth in RCW 48.01.040, and includes all policies and contracts offered by any insurer, as defined in subsection (1) of this section.

(3) "Complaint" means any written or documented oral communication primarily expressing a grievance, meaning an expression of dissatisfaction.

(4) "NAIC" means the National Association of Insurance Commissioners, and has the same meaning as in RCW 48.02.140.

(5) "Records" means any information from data available to the commissioner, surveys, required reports, information collected by the NAIC and other sources in both public and private sectors, and information from within and outside the insurance industry.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-010, filed 8/1/07, effective 9/1/07.]

WAC 284-37-020 Procedures manuals. To foster nationwide consistency in market conduct oversight, and as authorized by chapter 82, sections 6, 7 and 8, Laws of 2007 the commissioner adopts the following procedures and handbooks published by the NAIC and in effect on July 31, 2007, or as later amended. The applicable version of the procedure or handbook will be the version in effect when the relevant market conduct activity was initiated.

(1) *The NAIC Market Regulation Handbook* for all market conduct oversight activities, as defined at chapter 82, section 5(9), Laws of 2007.

(2) *The NAIC Market Conduct Uniform Examination Procedures* for all market conduct examinations, as defined at chapter 82, section 5(10), Laws of 2007.

(3) *The NAIC Standard Data Request* for all requests to insurers for market data, as defined at chapter 82, section 5(11), Laws of 2007.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-020, filed 8/1/07, effective 9/1/07.]

WAC 284-37-030 Access to records. During the market analysis process, the commissioner may require access to identifiable records in the possession of, or subject to control or access by the insurer. This section sets forth the process that the commissioner will follow when requesting records. Whenever possible and appropriate, the commissioner will make these requests electronically.

(1) The commissioner will contact the insurer in writing listing the records to be provided by the insurer for review.

(a) The list will specify the records required by the market conduct oversight personnel and will set forth the preferred method for transmission of records to the market conduct oversight team.

(b) The request will include the reason for the request and summarize how the records are intended to be used.

(2) All requested records must be provided to the commissioner within fifteen working days after receipt of the request.

(3)(a) If the insurer is not able to produce the requested records within the allotted time, the insurer must contact the commissioner before expiration of the allotted time and propose an alternative due date. The request must provide information about its reason for requesting a later due date.

(2009 Ed.)

(b) If the insurer is not able to produce the requested records in the format or manner requested by the market conduct oversight team, the insurer must contact the commissioner before expiration of the allotted time and propose an alternative delivery format.

(4) The commissioner will contact the insurer within five working days after receipt of any request for a later due date or alternative delivery format to discuss the proposed alternatives.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-030, filed 8/1/07, effective 9/1/07.]

WAC 284-37-040 Market conduct annual statement.

(1) Every insurer shall file with the commissioner its market conduct annual statement, as required by chapter 82, section 6, Laws of 2007, in accordance with filing instructions published by the NAIC.

(2) For purposes of this chapter, the market conduct annual statement filing is not complete until it has been received by the commissioner, in either hard copy or electronic form, as designated by the commissioner.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-040, filed 8/1/07, effective 9/1/07.]

WAC 284-37-050 Complaint verification. If a complaint is filed against an insurer, the commissioner will notify the insurer following this process. Whenever possible and appropriate, the commissioner will provide the notices detailed below to the insurer electronically.

(1) Initial notice to the insurer. The commissioner will send an initial notice to the insurer that identifies the name of the insurer against whom the complaint was filed using the insurer's name and NAIC number, and any other available identifying information as provided to the commissioner by the complainant.

(a) If the insurer disagrees with the name of the insurer as identified in the complaint, it must file an objection in writing no later than fifteen working days after the date the commissioner sends the notice to the insurer and attach appropriate supporting information or documentation.

(b) Failure of the insurer to object to the legal name and NAIC number provided in the initial notice of the complaint within the allotted time, will be considered to be the insurer's verification that the proper insurer is identified in the complaint.

(c) No extension of time to respond to the initial notice will be permitted except for good cause shown.

(2) Complaint closure notice. The commissioner will send a copy of the proposed complaint closure notice to the insurer at the time the complaint is closed. The complaint closure notice will identify the codes for both the type of coverage and reason for complaints that will be reported to the NAIC.

(a) If the insurer wishes to object to the coding to be reported to the NAIC, an objection must be filed with the commissioner within fifteen working days after the date that the complaint closure notice is sent to the insurer. The objection must contain a concise description of the nature of the objection to the proposed coding and must include appropriate supporting information or documentation.

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(b) Upon receipt of the insurer's objection, the commissioner will take reasonable and necessary steps to prevent reporting of that complaint to the NAIC until the insurer's objection is resolved.

(c) Failure of the insurer to object to the proposed coding set forth in the complaint closure notice will be considered verification that the complaint closure notice uses the correct codes and the notice will be reported to the NAIC.

(3) Opportunity to object to coding to be reported to the NAIC.

(a) Within ten working days after the commissioner receives an objection to proposed coding from the insurer, the commissioner will consider the information or documentation provided by the insurer and will advise the insurer that the original proposed coding has been affirmed or modified.

(b) The final complaint coding will be reported to the NAIC no sooner than five working days after resolution of an objection.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-050, filed 8/1/07, effective 9/1/07.]

WAC 284-37-060 Dispute resolution. As required at chapter 82, section 14(3), Laws of 2007, after the deputy insurance commissioner responsible for market conduct oversight has responded to an insurer's issues, the insurer may request mediation of the issues. The following process governs mediation of insurer market conduct oversight issues.

(1) A request for mediation of the issues must be made within five working days after receipt by the insurer of a final decision on any issue.

(2) The commissioner will maintain a list of approved mediators to mediate disputed issues. All approved mediators will be qualified by training and experience.

(a) The commissioner will publish a copy of the current resume and fee schedule of each panel mediator on the commissioner's web site (www.insurance.wa.gov).

(b) At the start of a market analysis process or the start of a market conduct examination, the insurer must select a mediator and alternate mediator from the approved list.

(c) The party requesting mediation is required to pay the costs of the mediator.

(3) As provided at chapter 82, section 14(4), Laws of 2007, at any point in the mediation, the insurer may commence an adjudicative proceeding under chapters 48.04 and 34.05 RCW.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-060, filed 8/1/07, effective 9/1/07.]

Chapter 284-43 WAC

HEALTH CARRIERS AND HEALTH PLANS

WAC

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284-43-040	Review and approval of certified health plan provider selection, termination, and dispute resolution provisions. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060 (2), 48.46.200 and 48.46.243.
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(2009 Ed.)

- 284-43-100 Health carrier standards for women's right to directly access certain health care practitioners for women's health care services. [Statutory Authority: RCW 48.02.-060, 48.18.120, 48.20.450, 48.20.460, 48.44.020, 48.44.050, 48.44.070, 48.46.200 and 48.46.243. 96-16-050 (Matter No. R 95-10), § 284-43-100, filed 8/1/96, effective 9/1/96.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.
- 284-43-210 Access plan. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-210, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-210, filed 1/22/98, effective 2/22/98.] Repealed by 08-17-037 (Matter No. R 2008-17), filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060.
- 284-43-610 Definitions. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-610, filed 11/29/99, effective 12/30/99.] Repealed by 01-03-033 (Matter No. R 2000-02), filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535.
- 284-43-700 Purpose. [Statutory Authority: RCW 48.02.060, 48.20.-450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-700, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.-450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.
- 284-43-710 Portability of health insurance benefits. [Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-710, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.-200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-710, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.
- 284-43-720 Guaranteed issue and restrictions on the denial, exclusion, or limitation of health benefits for preexisting conditions. [Statutory Authority: RCW 48.02.060, 48.18.-120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-720, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-720, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.
- 284-43-730 Guaranteed renewability—Health insurance. [Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-730, filed 1/22/98, effective 2/22/98.] Repealed by 08-09-022 (Matter No. R 2008-01), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.44.050, 48.46.030, 48.46.200.
- 284-43-810 Coverage for mental health services. [Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-810, filed 9/8/99, effective 10/9/99.] Repealed by 08-09-021 (Matter No. R 2008-02), filed 4/7/08, effective 5/8/08. Statutory Authority: RCW 48.02.060, 48.18.120(2), 48.20.450, 48.20.460, 48.44.050, 48.46.200. Later promulgation, see RCW 48.20.580, 48.21.240, 48.44.341 and 48.46.291.
- 284-43-821 Maternity and pregnancy-related exclusions, limitations and conditions in individual plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.-060. 01-03-035 (Matter No. R 2000-03), § 284-43-821, filed 1/9/01, effective 7/1/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.
- 284-43-823 Maternity and pregnancy-related exclusions, limitations and conditions in group plans. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.-060. 01-03-035 (Matter No. R 2000-03), § 284-43-823, filed 1/9/01, effective 7/1/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.
- 284-43-824 Effective date. [Statutory Authority: 2000 c 79 and RCW 48.43.041, 48.44.020, and 48.46.060. 01-03-035 (Matter No. R 2000-03), § 284-43-824, filed 1/9/01, effective 2/9/01.] Repealed by 01-19-001 (Matter No. R 2001-02), filed 9/5/01, effective 10/6/01. Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220.
- 284-43-900 Authority and purpose. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-900, filed 1/23/98, effective 3/1/98.] Repealed by 05-07-006 (Matter No. R 2004-05), filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200.
- 284-43-955 Effective date. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-955, filed 1/23/98, effective 3/1/98.] Repealed by 05-07-006 (Matter No. R 2004-05), filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.-050, and 48.46.200.

SUBCHAPTER A GENERAL PROVISIONS

WAC 284-43-110 Purpose. The purpose of this chapter is to establish uniform regulatory standards for health carriers and to create minimum standards for health plans that ensure consumer access to the health care services promised in these health plans.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-110, filed 1/22/98, effective 2/22/98.]

WAC 284-43-120 Applicability and scope. This chapter shall apply to all health plans and all health carriers subject to the jurisdiction of the state of Washington except as otherwise expressly provided in this chapter. Health carriers are responsible for compliance with the provisions of this chapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or require-

ments concerning the coverage of, payment for, or provision of health care services. A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier. Nothing in this chapter shall be construed to permit the direct regulation of health care providers or facilities by the office of the insurance commissioner.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-120, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-120, filed 1/22/98, effective 2/22/98.]

WAC 284-43-125 Compliance with state and federal laws. Health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-125, filed 1/24/00, effective 2/24/00.]

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination and noncertification" means a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

(2) "Certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" means an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat

an emergency medical condition, provided in a hospital emergency department.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding:

(a) Denial of health care services or payment for health care services; or

(b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(17) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit if the service is consistent with generally recognized standards within a relevant health profession.

(18) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(19) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(20) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(21) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology*, published by the American Medical Association.

(22) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(24) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(25) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

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

(27) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(28) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

(29) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(30) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-130, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. 01-03-032 (Matter No. R 2000-04), § 284-43-130, filed 1/9/01, effective 2/9/01. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.30.040, 48.44.110 and 48.46.400. 99-19-032 (Matter No. R 98-7), § 284-43-130, filed 9/8/99, effective 10/9/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-130, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER B HEALTH CARE NETWORKS

WAC 284-43-200 Network adequacy. (1) A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's service area shall not be created in a manner designed to discriminate against persons because of age, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter.

(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services

available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.

(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

(4) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Health carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees. In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.

(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.

(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.

(7) To provide adequate choice to covered persons who are American Indians, each health carrier shall maintain arrangements that ensure that American Indians who are covered persons have access to Indian health care services and facilities that are part of the Indian health system. Carriers shall ensure that such covered persons may obtain covered services from the Indian health system at no greater cost to the covered person than if the service were obtained from net-

work providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits a carrier from limiting coverage to those health services that meet carrier standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.-030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.]

WAC 284-43-205 Every category of health care providers. (1) To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the carrier's standards pursuant to RCW 48.43.045 (1)(b). For example, if the BHP provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) may not be excluded from the network.

(2) RCW 48.43.045 (1)(b) permits health carriers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, health carriers may not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers. However, health plans may not contain unreasonable limits, and may not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(b).

(4) This section does not prohibit health plans from using restricted networks. Health carriers offering plans with

restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. A health carrier is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan. Health plans that use "gatekeepers" for access to specialist providers may use them for access to specified categories of providers.

(5) Health carriers may not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.]

WAC 284-43-220 Network reports—Format. Each health carrier must file with the commissioner a Provider Network Form A, Network Enrollment Form B and Geographic Network Report.

(1) **Provider Network Form A.** A carrier must file an electronic report of all participating providers by network. This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month. Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describes changes in the provider network.

(2) **Network Enrollment Form B.** By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate report must be filed for each network by line of business. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(3) **Geographic Network Report.** By March 31st of every year, a carrier also must file an electronic or hard copy paper report meeting the standards below. The carrier must update the reports whenever a material change in the carrier's provider network occurs that significantly affects the ability of covered persons to access covered services. Each carrier must file for each network, using a network accessibility analysis system, such as GeoNetworks or any other similar system:

(a) A map showing the location of covered persons and primary care providers with a differentiation between single and multiple provider locations;

(b) An access table illustrating the relationship between primary care providers and covered persons as of December of each year by county, including at a minimum:

(i) Total number of covered persons;

(ii) Total number of primary care providers (or, if the plan is a Preferred Provider Organization style of managed care, the total number of contracted providers);

(iii) Number of covered persons meeting the carrier's self defined access standard;

(iv) Percentage of covered persons meeting the carrier's self defined access standard; and

(v) Average distance to at least one primary care provider for its covered persons; and

(c) An alphabetical list by county and city showing:

(i) Total number of covered persons;

(ii) Total number of primary care providers (or, if the plan is a Preferred Provider Organization style of managed care, the total number of contracted providers);

(iii) Total number of obstetric and women's health care providers;

(iv) Total number of specialists;

(v) Total number of nonphysician providers by license type;

(vi) Total number of hospitals; and

(vii) Total number of pharmacies.

(4) A carrier may vary the method of reporting required under subsection (3) of this section upon written request and subsequent written approval by the commissioner. In the request, the carrier must show that the carrier does not use or does not have easy access to electronic or data systems permitting the method of reporting required without incurring substantial costs.

(5) For purposes of this section:

(a) "Line of business" means either individual, small group or large group coverage;

(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.

[Statutory Authority: RCW 48.02.060, 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.]

WAC 284-43-250 Health carrier standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a)

"Women's health care services" is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is

within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) A carrier may not exclude or limit access to covered women's health care services offered by a particular type of women's health care practitioner in a manner that would unreasonably restrict access to that type of provider or covered service. For example, a carrier may not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician thus, preventing a woman from choosing and using the birthing services of an advanced registered nurse practitioner specialist in midwifery.

(c) A carrier may not impose notification or prior authorization requirements upon women's health care practitioners who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, a carrier may not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the carrier for the same or similar service.

(2) A health carrier shall not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. A health carrier shall not require authorization by another type of health care practitioner for these services. For example, if the carrier would cover a prescription if the prescription had been written by the primary care provider, the carrier shall cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All health carriers shall permit each female policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995, to directly access the types of women's health care practitioners identified in RCW 48.42-100(2), for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) Beginning July 1, 2000, direct access may be limited to those women's health care practitioners who have signed participating provider agreements with the carrier for a specific benefit plan network. Irrespective of the financial arrangements a carrier may have with participating providers, a carrier may not limit and shall not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to a covered person and then represents to the covered person that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection shall be interpreted to prohibit a carrier

from contracting with a provider to render limited health care services.

(c) Every carrier shall include in each provider network, a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2) to ensure that enrollees can exercise their right of direct access.

(d) Beginning July 1, 2000, a woman's right to directly access practitioners for health care services as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all health carriers shall include in enrollee handbooks a written explanation of a woman's right to directly access women's health care practitioners for covered women's health care services. Enrollee handbooks shall include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The carrier's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No carrier shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200, 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.-080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.]

WAC 284-43-251 Covered person's access to providers.

(1) Each carrier must allow a covered person to choose a primary care provider who is accepting new patients from a list of participating providers. Covered persons also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the covered person's request for the change.

(2) Each carrier must have a process whereby a covered person with a complex or serious medical or psychiatric condition may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the covered person's medical needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude carrier performance of utilization review functions.

(3) Each carrier shall provide covered persons with direct access to the participating chiropractor of the covered person's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent carriers from restricting covered persons to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services

as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(4) Each carrier must provide, upon the request of a covered person, access by the covered person to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the covered person's choice. The carrier may not impose any charge or cost upon the covered person for such second opinion other than a charge or cost imposed for the same service in otherwise similar circumstances.

(5) Each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the covered persons or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to covered persons shall include information of the covered person's right of access to the terminating provider for an additional sixty days. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new covered persons to the terminated provider.

(6) Each carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.]

WAC 284-43-260 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. It is a longstanding and widespread practice for contracted network providers to retain substitute providers to take over their professional practices when the contracted network providers are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for contracted network providers to bill and receive payment for the substitute providers' services as though they were provided by the contracted network provider. The contracted network provider generally pays the substitute provider based on an agreement between the contracted network provider and the substitute provider, and the substitute provider has the status of an independent contractor rather than an employee of the contracted network provider. These substitute providers are commonly called "locum tenens" providers.

In order to protect patients and ensure that they benefit from seamless quality care when contractual network providers are away from their practices, and that patients receive quality care from qualified substitute providers, carriers may require substitute providers to provide the information required in subsection (1) of this section.

(2009 Ed.)

The following are minimum standards for temporary provider substitution and do not prevent a carrier from entering into other agreed arrangements with its contracted network providers for terms that are less restrictive or more favorable to providers.

Carriers must permit the following categories of contracted network provider to arrange for temporary substitution by a substitute provider: Doctor of medicine, doctor of osteopathic medicine, doctor of dental surgery or dental medicine, doctor of chiropractic, podiatric physician and surgeon, doctor of optometry, doctor of naturopathic medicine and advanced registered nurse practitioner.

(1) At the time of substitution, the substitute provider:

(a) Must have a current Washington license and be legally authorized to practice in this state;

(b) Must provide services under the same scope of practice as the contracted network provider;

(c) Must not be suspended or excluded from any state or federal health care program;

(d) Must have professional liability insurance coverage; and

(e) Must have a current drug enforcement certificate, if applicable.

(2)(a) Carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year.

(b) A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

(3) A carrier may require that the contracted network provider agree to bill for services rendered by the substitute provider using the carrier's billing guidelines, including use of HIPAA compliant code sets, commonly known as the Q-6 modifier, or any other code or modifier that the Centers for Medicare and Medicaid Services (CMS) adopts in the future.

(4) Nothing in this section is intended to prevent the carrier from requiring:

(a) That the contracted network provider require acceptance by the substitute provider of the carrier's fee schedule; or

(b) Acceptance by the substitute provider of the carrier's usual and customary charge as payment in full.

(5) This rule does not apply to Medicare Advantage or other health plans administered by the federal government that require precertification of all providers.

[Statutory Authority: RCW 48.02.060 and 48.43.515. 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.]

WAC 284-43-262 Rule concerning contracted network providers called to active duty military service. In lieu of substitution of a provider during a period of active duty military service longer than sixty continuous days, carriers must provide contracted network providers with the opportunity to return to the carrier's network after the provider's active duty military service is completed.

(1)(a) A carrier must allow the provider a period of at least one hundred twenty days to request a return to contracted network provider status after the provider returns to civilian status.

(b) The one hundred twenty-day period must begin no earlier than the date the provider's period of active duty ends.

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(2)(a) As a condition for return to the carrier's network, the carrier may require that the provider provide evidence that he or she meets the carrier's then-current standards for credentialing.

(b) If the provider meets or exceeds the credentialing standards of the carrier and timely requests a return to contracted network provider status, the carrier must grant the request whether or not the carrier's network is otherwise closed.

[Statutory Authority: RCW 48.02.060 and 48.43.515. 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.]

SUBCHAPTER C PROVIDER CONTRACTS AND PAYMENT

WAC 284-43-300 Provider and facility contracts with health carriers—Generally. A health carrier contracting with providers or facilities for health care service delivery to covered persons shall satisfy all the requirements contained in this subchapter. The health carrier shall ensure that providers and facilities subcontracting with these providers and facilities under direct contract with the carrier also satisfy the requirements of this subchapter.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-300, filed 1/22/98, effective 2/22/98.]

WAC 284-43-310 Selection of participating providers—Credentialing and unfair discrimination. (1) Health carrier selection standards for participating providers and facilities shall be developed by the carrier for primary care providers and each health care provider or facility license or professional specialty. The standards shall be used in determining the selection of health care providers and facilities by the health carrier. The standards shall be consistent with rules or standards established by the state department of health or other regulatory authority established in Title 18 RCW for health care providers specified in RCW 18.130.040. Selection criteria shall not be established in a manner:

(a) That would allow a health carrier to avoid risk by excluding providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or

(b) That would exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations.

(2) The provisions of subsection (1)(a) and (b) of this section shall not be construed to prohibit a carrier from declining to select a provider or facility who fails to meet other legitimate selection criteria of the carrier. The purpose of these provisions is to prevent network creation and provider or facility selection to serve as a substitute for prohibited health risk avoidance or prohibited discrimination.

(3) The provisions of this subchapter do not require a health carrier to employ, to contract with, or retain more providers or facilities than are necessary to comply with the network adequacy standards of this chapter.

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(4) A health carrier shall make its selection standards for participating providers and facilities available for review upon request by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-310, filed 1/22/98, effective 2/22/98.]

WAC 284-43-320 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by a health carrier shall not relieve the health carrier of its obligations to any covered person for the provision of health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts shall be in writing and available for review upon request by the commissioner.

(1) A health carrier shall establish a mechanism by which its participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits.

Nothing contained in a participating provider or a participating facility contract may have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the contract and a health plan, the benefits, terms, and conditions of the health plan shall govern with respect to coverage provided to covered persons.

(2) Each participating provider and participating facility contract shall contain the following provisions or variations approved by the commissioner:

(a) "{Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of carrier}, {name of carrier's} insolvency, or breach of this contract shall {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or person acting on their behalf, other than {name of carrier}, for services provided pursuant to this contract. This provision shall not prohibit collection of {deductibles, copayments, coinsurance, 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 covered persons in accordance with the terms of the covered person's health plan."

(b) "{Name of provider or facility} agrees, in the event of {name of carrier's} insolvency, to continue to provide the services promised in this contract to covered persons of {name of carrier} for the duration of the period for which premiums on behalf of the covered person were paid to {Name of carrier} or until the covered person'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 covered person's health plan."

(d) "{Name of provider or facility} may not bill the covered person for covered services (except for deductibles, copayments, or coinsurance) where {name of carrier} denies

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payments because the provider or facility has failed to comply with the terms or conditions of this contract."

(e) "{Name of provider or facility} further agrees (i) that the provisions of (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 carrier's} covered persons, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {name of provider or facility} and covered persons or persons acting on their behalf."

(f) "If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to covered persons of {name of carrier} with the expectation of receiving payment directly or indirectly from {name of carrier}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

(3) The contract shall inform participating providers and facilities that willfully collecting or attempting to collect an amount from a covered person knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

(4) A health carrier shall notify participating providers and facilities of their responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements.

Documents, procedures, and other administrative policies and programs referenced in the contract must be available for review by the provider or facility prior to contracting. Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes. No change to the contract may be made retroactive without the express consent of the provider or facility.

(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:

(a) "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

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(b) "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

(6) A health carrier shall require participating providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons subject to applicable state and federal laws related to the confidentiality of medical or health records.

(7) A health carrier and participating provider and facility shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, that carrier shall make a good faith effort to assure that notice is provided to all covered persons who are patients of that primary care provider.

(8) A health carrier is responsible for ensuring that participating providers and facilities furnish covered services to covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(9) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare or that may violate state or federal law.

(10) The following provision is a restatement of a statutory requirement found in RCW 48.43.085: "Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan."

(11) Every participating provider contract shall contain procedures for the fair resolution of disputes arising out of the contract.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

WAC 284-43-321 Provider contracts—Terms and conditions of payment. (1) Every participating provider and facility contract shall set forth a schedule for the prompt pay-

ment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.

(2)(a) For health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

(b) The receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

(c) The carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(e) When the carrier issues payment in either the provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the provider or facility first and the covered person second.

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

(5) Every carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the carrier or acting pursuant to carrier standards or requirements complies with these billing and claim payment standards.

(6) These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities or covered persons, or instances where the carrier has not been granted reasonable access to information under the provider's or facility's control.

(7) Providers, facilities, and carriers are not required to comply with these contract provisions if the failure to comply

is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.]

WAC 284-43-322 Provider contracts—Dispute resolution process. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider or facility contract shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of this section.

(1) A dispute resolution process may include an initial informal process but must include a formal process for resolution of all contract disputes.

(2) A carrier may have different types of dispute resolution processes as necessary for specialized concerns such as provider credentialing or as otherwise required by law. For example, disputes over health plan coverage of health care services are subject to the grievance procedures established for covered persons.

(3) Carriers must allow not less than thirty days after the action giving rise to a dispute for providers and facilities to complain and initiate the dispute resolution process.

(4) Carriers may not require alternative dispute resolution to the exclusion of judicial remedies; however, carriers may require alternative dispute resolution prior to judicial remedies.

(5) Carriers must render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, the carrier must render a decision within sixty days of the complaint.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.]

WAC 284-43-323 Pharmacy identification cards. (1) This rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

(2) The pharmacy identification card or other technology must include the data element consistent with the "BIN number," "IIN/BIN number" or "RxBIN" which is the ANSI assigned international identification number, identified in the *National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card Implementation Guide*. Other data elements of the *NCPDP Guide* must be included on the card only if they are required for the processing of claims.

(3) This rule does not compel the issuance of a separate pharmacy identification card provided that the enrollee health plan identification card contains the required data elements.

(4) All plans that use a card or other technology for prescription claims processing that are delivered, issued for delivery or renewed on or after July 1, 2003, must comply with the requirements of this rule.

[Statutory Authority: RCW 48.02.060, 48.43.023, 48.44.050, 48.46.200. 03-07-006 (Matter No. R 2002-04), § 284-43-323, filed 3/6/03, effective 4/6/03.]

WAC 284-43-324 Provider contracts—Audit guidelines. (1) Provider and facility contracts may not contain provisions that grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier's right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

(2) Provider and facility contract provisions granting the carrier access to medical records for audit purposes must be limited to only that necessary to perform the audit.

(3) Provider and facility contracts may not contain billing audit standards that are not mutual. For example, if the carrier grants itself the right to audit hospital billing records, then the hospital has the right to audit carrier denials of the hospital's claims.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.]

WAC 284-43-330 Participating provider—Filing and approval. (1) Beginning May 1, 1998, a health carrier shall file with the commissioner fifteen working days prior to use sample contract forms proposed for use with its participating providers and facilities. A health carrier need not submit contract provisions governing payment rates, amounts, or similar proprietary information that would indicate provider or facility compensation.

(2) A health carrier shall submit material changes to a sample contract form to the commissioner fifteen working days prior to use. Carriers shall indicate in the filing whether any change affects a provision required by this chapter. All changes to contracts must be indicated through strike outs for deletions and underlines for new material. Alternatively, carriers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes. Changes not affecting a provision required by this chapter are deemed approved upon filing.

(3) If the commissioner takes no action within fifteen working days after submission of a sample contract or a material change to a sample contract form by a health carrier, the change or form is deemed approved except that the commissioner may extend the approval period an additional fifteen working days upon giving notice before the expiration of the initial fifteen-day period. Approval may be subsequently withdrawn for cause.

(4) The health carrier shall maintain provider and facility contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.]

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective

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date of these rules shall comply with these rules no later than July 1, 2000.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules shall be amended upon renewal to comply with these rules, and all such contracts shall conform to these provisions no later than January 1, 2001. The commissioner may extend the January 1, 2001, deadline for a health carrier for an additional six months, if the health carrier makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the health carrier expects to be in compliance (no more than six months beyond January 1, 2001).

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.]

WAC 284-43-340 Effective date. (1) All participating provider and facility contracts entered into after the effective date of this subchapter shall comply with this subchapter no later than July 1, 1998.

(2) Participating provider and facility contracts entered into prior to the effective date of this subchapter shall be amended upon renewal to comply with the provisions of this subchapter, and all such contracts shall conform to the provisions of this subchapter no later than July 1, 1999. The commissioner may extend the July 1, 1999 deadline, for an additional period not to exceed six months if the health carrier demonstrates good cause for an extension.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-340, filed 1/22/98, effective 2/22/98.]

SUBCHAPTER D UTILIZATION REVIEW

WAC 284-43-410 Utilization review—Generally. (1) Each carrier shall maintain a documented utilization review program description and written clinical review criteria based on reasonable medical evidence. The program must include a method for reviewing and updating criteria. Carriers shall make clinical review criteria available upon request to participating providers. A carrier need not use medical evidence or standards in its utilization review of religious nonmedical treatment or religious nonmedical nursing care.

(2) The utilization review program shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter and shall have staff who are properly qualified, trained, supervised, and supported by explicit written clinical review criteria and review procedures.

(3) Each carrier when conducting utilization review shall:

(a) Accept information from any reasonably reliable source that will assist in the certification process;

(b) Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;

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(c) Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;

(d) Not routinely request copies of medical records on all patients reviewed;

(e) Require only the section(s) of the medical record during prospective review or concurrent review necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service;

(f) For prospective and concurrent review, base review determinations solely on the medical information obtained by the carrier at the time of the review determination;

(g) For retrospective review, base review determinations solely on the medical information available to the attending physician or order provider at the time the health service was provided;

(h) Not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider;

(i) Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and

(j) Reverse its certification determination only when information provided to the carrier is materially different from that which was reasonably available at the time of the original determination.

(4) Each carrier shall reimburse reasonable costs of medical record duplication for reviews.

(5) Each carrier shall have written procedures to assure that reviews and second opinions are conducted in a timely manner.

(a) Review determinations must be made within two business days of receipt of the necessary information on a proposed admission or service requiring a review determination.

(b) The frequency of reviews for the extension of initial determinations must be based upon the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(c) Retrospective review determinations must be completed within thirty days of receipt of the necessary information.

(d) Notification of the determination shall be provided to the attending physician or ordering provider or facility and to the covered person within two days of the determination and shall be provided within one day of concurrent review determination. Notification shall include the number of extended days, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(6) No carrier may penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the carrier's determination with respect to coverage or payment for health care service.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-410, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER F GRIEVANCE AND COMPLAINT PROCEDURES

WAC 284-43-615 Grievance and complaint procedures—Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations. This process shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(2) This process must conform to the provisions of this chapter and each carrier must:

(a) Provide a clear explanation of the grievance process upon request, upon enrollment to new covered persons, and annually to covered person and subcontractors of the carrier.

(b) Ensure that the grievance process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(c) Process as a grievance a covered person's expression of dissatisfaction about customer service or the quality or availability of a health service.

(d) Implement procedures for registering and responding to oral and written grievances in a timely and thorough manner including the notification of a covered person that a grievance or appeal has been received.

(e) Assist the covered person with all grievance and appeal processes.

(f) Cooperate with any representative authorized in writing by the covered person.

(g) Consider all information submitted by the covered person or representative.

(h) Investigate and resolve all grievances and appeals.

(i) Provide information on the covered person's right to obtain second opinions.

(j) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-615, filed 1/9/01, effective 7/1/01.]

WAC 284-43-620 Procedures for review and appeal of adverse determinations. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the coverage person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the covered person's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of a covered person appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the covered person or a provider acting on behalf of the covered person.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the covered person a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-620, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-43-620, filed 11/29/99, effective 12/30/99.]

WAC 284-43-630 Independent review of adverse determinations. Carriers must use the rotational registry system of certified independent review organizations (IRO) established by the commissioner.

(1) Carriers must select reviewing IROs in the rotational manner described in the rotational registry system. A carrier may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030.

(2) The rotational registry system, a current list of certified IROs, IRO assignment instructions, and an IRO assignment form to be used by carriers are set forth on the insurance commissioner's web site (www.insurance.wa.gov).

(3) In addition to the requirements set forth in RCW 48.43.535(4), carriers must:

(a) Make available to the covered person and to any provider acting on behalf of the covered person all materials provided to an independent review organization reviewing the carrier's determination; and

(b) Provide IROs with:

(i) All relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

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(ii) The attending or ordering provider's recommendations; and

(iii) A copy of the terms and conditions of coverage under the relevant health plan.

(4) Carriers must report to the commissioner each assignment made to an IRO not later than three business days after an assignment is made. Information regarding the enrollee's personal health should not be provided with the report.

(5) The requirements of this section are in addition to the requirements set forth in RCW 48.43.535 and 43.70.235, and rules adopted by the department of health in chapter 246-305 WAC.

[Statutory Authority: RCW 48.02.060 and 48.53.535(10). 08-07-101 (Matter R 2006-11), § 284-43-630, filed 3/19/08, effective 4/19/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-630, filed 1/9/01, effective 7/1/01.]

SUBCHAPTER H HEALTH PLAN BENEFITS

WAC 284-43-800 Recognizing the exercise of conscience by purchasers of basic health plan services and ensuring access for all enrollees to such services. (1) All carriers required pursuant to law to offer and file with the commissioner a plan providing benefits identical to the basic health plan services (the model plan) shall file for such plan a full description of the process it will use to recognize an organization or individual's exercise of conscience based on a religious belief or conscientious objection to the purchase of coverage for a specific service. This process may not affect a nonobjecting enrollee's access to coverage for those services.

(2) A religiously sponsored carrier who elects, for reasons of religious belief, not to participate in the provision of certain services otherwise included in the model plan, shall file for such plan a description of the process by which enrollees will have timely access to all services in the model plan.

(3) The commissioner will not disapprove processes that meet the following criteria:

(a) Enrollee access to all basic health plan services is not impaired in any way;

(b) The process meets notification requirements specified in RCW 48.43.065; and

(c) The process relies on sound actuarial principles to distribute risk.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. 98-04-005 (Matter No. R 97-3), § 284-43-800, filed 1/22/98, effective 2/22/98.]

WAC 284-43-815 Coverage for pharmacy services.

(1) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the following statement is not provided to covered persons at the time of enrollment:

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what cov-

erage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (the health carrier) at 1-800-???-????.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

(2) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the carrier does not: Pose and respond in writing to the following questions in language that complies with WAC 284-50-010 through 284-50-230; offers to provide and provide upon request this information prior to enrollment; and ensures that this information is provided to covered persons at the time of enrollment:

(a) **"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"** The response must describe the process for developing coverage standards and formularies, including the principal criteria by which drugs are selected for inclusion, exclusion, restriction or limitation. If a determination of medical necessity is used, that term must be briefly defined here. Coverage standards involving the use of substitute drugs, whether generic or therapeutic, are either an exception, reduction or limitation and must be discussed here. Major categories of drugs excluded, limited or reduced from coverage may be included in this response.

(b) **"When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"** The response must identify the process of changing formularies and coverage standards, including changes in the use of substitute drugs. If the plan gives prior notice of these changes or has provisions for "grandfathering" certain ongoing prescriptions, these practices may be discussed here.

(c) **"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"** The response must include a phone number to call with a request for a change in coverage decisions, and must discuss the process and criteria by which such a change may be granted. The response may refer to the appeals or grievance process without describing that process in detail here. The response must state the time within which requests for changes will be acted upon in normal circumstances and in circumstances where an emergency medical condition exists.

(d) **"How much do I have to pay to get a prescription filled?"** The response must list enrollee point-of-service cost-sharing dollar amounts or percentages for all coverage categories including at least name brand drugs, substitute drugs and any drugs which may be available, but which are not on the health plan's formulary.

(e) **"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"** If the answer to this question is "yes," the plan must state the

approximate number of pharmacies in Washington at which the most favorable enrollee cost sharing will be provided, and some means by which the enrollee can learn which ones they are.

(f) **"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"** The response should discuss normal and exceptional supply limits, mail order arrangements and travel supply and refill requirements or guidelines.

(g) **"What other pharmacy services does my health plan cover?"** The response should include any "intellectual services," or disease management services reimbursed by the plan in addition to those required under state and federal law in connection with dispensing, such as disease management services for migraine, diabetes, smoking cessation, asthma, or lipid management.

(3) The commissioner may disapprove any contract issued or renewed after July 1, 2001, that includes coverage for pharmacy services if the general categories of drugs excluded from coverage are not provided to covered persons at the time of enrollment. Such categories may include items such as appetite suppressants, dental prescriptions, cosmetic agents or most over-the-counter medications. This subsection intends only to promote clearer enrollee understanding of the exclusions, reductions and limitations contained in a health plan, and not to suggest that any particular categories of coverage for drugs or pharmacy services should be excluded, reduced, or limited by a health plan.

(4) In complying with these requirements, a carrier may, where appropriate and consistent with the provisions of these rules, consolidate the information with other material required by disclosure provisions set forth in RCW 48.43.510 and WAC 284-43-820.

(5) This information may be provided in a narrative form to the extent that the content of both questions and answers is included.

(6) The commissioner may grant an extension or waive these requirements for good cause and if there is assurance that the information, required herein, is distributed in a timely manner consistent with the purpose and intent of these rules.

[Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.200, 2000 c 79 § 26, and RCW 48.30.040, 48.44.110, 48.46.400. 01-03-032 (Matter No. R 2000-04), § 284-43-815, filed 1/9/01, effective 2/9/01.]

WAC 284-43-820 Health plan disclosures—Prescription drugs, preventive care, generally. (1) A carrier that offers a health plan may not offer to sell a health plan to an enrollee or to any group representative, agent, employer, or enrollee representative without first offering to provide, and providing upon request, the following information using a standardized summary format filed with the commissioner and consistent with WAC 284-43-815 before purchase or selection:

(a) A listing of covered benefits, including prescription drug benefits, if any, and how consumers may be involved in decisions about benefits;

(b) A listing of exclusions, reductions, and limitations to covered benefits, including definitions of terms such as formulary, generic versus brand name, medical necessity or other coverage criteria and policies regarding coverage of

drugs, including how drugs are added or removed from the formulary;

(c) A statement of the carrier's policies for protecting the confidentiality of health information;

(d) A statement of the cost of premiums and any enrollee cost-sharing requirements;

(e) A summary explanation of the carrier's grievance process;

(f) A statement regarding the availability of a point-of-service option, if any, and how the option operates; and

(g) A convenient means of obtaining a complete and detailed list of covered benefits including a copy of the current formulary, if any is used, a list of participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within any plan network. The offer to provide the information referenced in this subsection (1) must be clearly and prominently displayed on any information provided to any prospective enrollee or to any prospective group representative, agent, employer, or enrollee representative.

(2) Upon the request of any person, including a current enrollee, prospective enrollee, or the insurance commissioner, a carrier must provide written information regarding any health care plan it offers, that includes the following written information:

(a) Any documents, instruments, or other information referred to in the medical coverage agreement;

(b) A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral;

(c) Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services;

(d) A written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider or network;

(e) Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;

(f) An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;

(g) A copy of the carrier's grievance process for claim or service denial and for dissatisfaction with care; and

(h) Accreditation status with one or more national managed care accreditation organizations, and whether the carrier tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

(3) Each carrier shall provide to all enrollees and prospective enrollees a list of available disclosure items.

(4) Nothing in this section requires a carrier or a health care provider to divulge proprietary information to an enrollee, including the specific contractual terms and conditions between a carrier and a particular provider.

(5) No carrier may advertise or market any health plan to the public, including to any employer as a plan that covers services that help prevent illness or promote the health of enrollees unless it:

(a) Provides all clinical preventive health services provided by the basic health plan, authorized by chapter 70.47 RCW;

(b) Monitors and reports annually to enrollees on standardized measures of health care and satisfaction of all enrollees in the health plan. Standardized measures for this purpose, include HEDIS, consumer assessment of health plans (CAHP) or other national standardized measurement systems adopted by national managed care accreditation organizations or state agencies that purchase managed health care services and approved by the commissioner; and

(c) Makes available upon request to enrollees its integrated plan to identify and manage the most prevalent diseases within its enrolled population, including cancer, heart disease, and stroke. Such plans must include means to identify enrollees with these diseases, implement evidence based screening, education, monitoring and treatment protocols, track patient and provider adherence to these protocols, measure health outcomes, and regularly report results to enrollees.

(6) No carrier may preclude or discourage its providers from informing an enrollee of the care he or she requires, including various treatment options, and whether in the providers' view such care is consistent with the plan's health coverage criteria, or otherwise covered by the enrollee's medical coverage agreement with the carrier. No carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of an enrollee with a carrier. Nothing in this section shall be construed to authorize a provider to bind a carrier to pay for any service.

(7) No carrier may preclude or discourage enrollees or those paying for their coverage from discussing the comparative merits of different carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

(8) Each carrier must communicate enrollee information required in this act by means that ensure that a substantial portion of the enrollee population can make use of the information.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-820, filed 1/9/01, effective 7/1/01.]

WAC 284-43-822 Unfair practice relating to health coverage. (1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.

An example of a plan that provides generally comprehensive coverage of prescription drugs is a plan that covers

prescription drugs but excludes some categories such as weight reduction or smoking cessation.

(2)(a) Health plans providing generally comprehensive coverage of prescription drugs and/or prescription devices shall not exclude prescription contraceptives or cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

(b) Health plans may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.

(c) Health plans may require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives, to the same extent that such cost sharing is required for other covered prescription drugs, devices or services.

(d) Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception as defined in (f) of this subsection.

(e) If a health plan excludes coverage for nonprescription drugs and devices except for those required by law, it may also exclude coverage for nonprescription contraceptive drugs and devices.

(f) For purposes of subsections (1) and (2) of this section, "prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

(g) This section applies prospectively to health plans offered, issued, or renewed by a health carrier on or after January 1, 2002.

[Statutory Authority: RCW 48.02.060, 48.18.480, 48.20.450, 48.20.460, 48.21.045, 48.30.010, 48.30.300, 48.41.110, 48.41.170, 48.42.010, 48.42.040, 48.42.100, 48.43.012, 48.43.025, 48.43.035, 48.43.041, 48.43.115, 48.43.520, 48.44.020, 48.44.023, 48.44.050, 48.44.220, 48.46.060, 48.46.066, 48.46.110, 48.46.200, 49.60.010, 49.60.030, 49.60.120, 49.60.178, 49.60.220. 01-19-001 (Matter No. R 2001-02), § 284-43-822, filed 9/5/01, effective 10/6/01.]

WAC 284-43-899 Effective date. The effective date of WAC 284-43-130, 284-43-200, 284-43-251, 284-43-400, 284-43-410, 284-43-610, 284-43-615, 284-43-620, 284-43-630, and 284-43-820 is July 1, 2001.

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. 01-03-033 (Matter No. R 2000-02), § 284-43-899, filed 1/9/01, effective 2/9/01.]

SUBCHAPTER I—HEALTH PLAN RATES

WAC 284-43-901 Authority and purpose. This subchapter is adopted under the general authority of RCW

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48.02.060, 48.44.017, 48.44.020, 48.44.050, 48.46.060, 48.46.062, and 48.46.200. Its purpose is to provide guidelines for the implementation of RCW 48.44.017(2), 48.44.020(3), 48.44.022, 48.44.023, 48.44.040, 48.46.060 (4) and (6), 48.46.062(2), 48.46.064, and 48.46.066 as to the filing of contract forms by health care service contractors and health maintenance organizations and the calculations and evaluations of premium rates for these contracts.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-901, filed 9/25/08, effective 10/26/08.]

WAC 284-43-905 Applicability and scope. This subchapter applies to health benefit plans as defined in RCW 48.43.005, and contracts for limited health care services as defined in RCW 48.44.035, offered by health care service contractors and health maintenance organizations transacting business in this state under chapter 48.44 or 48.46 RCW. It applies to such plans purchased directly by individuals, small employers, large employers and other organizations.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-905, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-905, filed 1/23/98, effective 3/1/98.]

WAC 284-43-910 Definitions. For the purpose of this subchapter:

(1) "Adjusted earned premium" means the amount of "earned premium" the "carrier" would have earned had the "carrier" charged current "premium rates" for all applicable "plans."

(2) "Annualized earned premium" means the "earned premium" that would be earned in a twelve-month period if earned at the same rate as during the applicable period.

(3) "Anticipated loss ratio" means the "projected incurred claims" divided by the "projected earned premium."

(4) "Base rate" means the "premium" for a specific "plan," expressed as a monthly amount per "covered person or subscriber," prior to any adjustments for geographic area, age, family size, wellness activities, tenure, or any other factors as may be allowed.

(5) "Capitation expenses" means the amount paid to a provider or facility on a per "covered person" basis, or as part of risk-sharing provisions, for the coverage of specified health care services.

(6) "Carrier" means a health care service contractor or health maintenance organization.

(7) "Certificate" means the statement of coverage document furnished "subscribers" covered under a "group contract."

(8) "Claim reserves" means the "claims" that have been reported but not paid plus the "claims" that have not been reported but may be reasonably expected.

(9) "Claims" means the cost to the "carrier" of health care services provided to a "covered person" or paid to or on behalf of the "covered person" in accordance with the terms of a "plan." This includes "capitation payments" or other similar payments made to providers or facilities for the purpose of paying for health care services for a "covered person."

(10) "Community rate" means the weighted average of all "premium rates" within a filing with the weights determined according to current enrollment.

(11) "Contract" means an agreement to provide health care services or pay health care costs for or on behalf of a "subscriber" or group of "subscribers" and such eligible dependents as may be included therein.

(12) "Contract form" means the prototype of a "contract" and any associated riders and endorsements filed with the commissioner by a health care service contractor or health maintenance organization.

(13) "Contribution to surplus, contingency charges, or risk charges" means the portion of the "projected earned premium" not associated directly with "claims" or "expenses."

(14) "Covered person" or "enrollee" has the same meaning as that contained in RCW 48.43.005.

(15) "Current community rate" means the weighted average of the "community rates" at the renewal or initial effective dates of each plan for the year immediately preceding the renewal period, with weights determined according to current enrollment.

(16) "Current enrollment" means the monthly average number and demographic makeup of the "covered persons" for the applicable contracts during the most recent twelve months for which information is available to the carrier.

(17) "Earned premium" means the "premium" plus any rate credits or recoupments, applicable to an accounting period whether received before, during, or after such period.

(18) "Expenses" means costs that include but are not limited to the following:

- (a) Claim adjudication costs;
- (b) Utilization management costs if distinguishable from "claims";
- (c) Home office and field overhead;
- (d) Acquisition and selling costs;
- (e) Taxes; and
- (f) All other costs except "claims."

(19) "Experience period" means the most recent twelve-month period from which the carrier accumulates the data to support a filing.

(20) "Extraordinary expenses" means "expenses" resulting from occurrences atypical of the normal business activities of the "carrier" that are not expected to recur regularly in the near future.

(21) "Group contract" or "group plan" means 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 the dependents of such employees or members.

(22) "Incurred claims" means "claims" paid during the applicable period plus the "claim reserves" as of the end of the applicable period minus the "claim reserves" as of the beginning of the applicable period. Alternatively, for the purpose of providing monthly data or trend analysis, "incurred claims" may be defined as the current best estimate of the "claims" for services provided during the applicable period.

(23) "Individual contract" means a "contract" issued to and covering an individual. An "individual contract" may include dependents.

(24) "Investment earnings" means the income, dividends, and realized capital gains earned on an asset.

(25) "Loss ratio" means "incurred claims" as a percentage of "earned premiums" before any deductions.

(26) "Medical care component of the consumer price index for all urban consumers" means the similarly named figure published monthly by the United States Bureau of Labor Statistics.

(27) "Net worth or reserves and unassigned funds" means the excess of assets over liabilities on a statutory basis.

(28) "Plan" means a "contract" that is a health benefit plan as defined in RCW 48.43.005 or a "contract" for limited health care services as defined in RCW 48.44.035.

(29) "Premium" has the same meaning as that contained in RCW 48.43.005.

(30) "Premium rate" means the "premium" per "subscriber" or "covered person" obtained by adjusting the "base rate" for geographic area, family size, age, wellness activities, or any other factors as may be allowed.

(31) "Projected earned premium" means the "earned premium" that would be derived from applying the proposed "premium rates" to the current enrollment.

(32) "Projected incurred claims" means the estimate of "incurred claims" for the rate renewal period based on the current enrollment.

(33) "Proposed community rate" means the weighted average of the "community rates" at the renewal dates of each plan for the renewal period, with weights determined according to current enrollment.

(34) "Provider" has the same meaning as that contained in RCW 48.43.005.

(35) "Rate renewal period" means the period for which the proposed "premium rates" are intended to remain in effect.

(36) "Rate schedule" means the schedule of all "base rates" for "plans" included in the filing.

(37) "Requested increase in the community rate" means the amount, expressed as a percentage, by which the "proposed community rate" exceeds the "current community rate."

(38) "Service type" means the category of service for which "claims" are paid, such as hospital, professional, dental, prescription drug, or other.

(39) "Small group contracts" or "small group plans" means the class of "group contracts" issued to "small employers," as that term is defined in RCW 48.43.005.

(40) "Staffing data" means statistics on the number of providers and associated compensation required to provide a fixed number of services or provide services to a fixed number of "covered persons."

(41) "Subscriber" means a person on whose behalf a "contract" or "certificate" is issued.

(42) "Unit cost data" means statistics on the cost per health care service provided to a "covered person."

(43) "Utilization data" means statistics on the number of services used by a fixed number of "covered persons" over a fixed length of time.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-910, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-910, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.-050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d)

and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-910, filed 1/23/98, effective 3/1/98.]

WAC 284-43-915 Demonstration that benefits provided are not reasonable in relation to the amount charged for a contract per RCW 48.44.020 and 48.46.060.

(1) The provisions of this section are in addition to the requirements set forth in RCW 48.44.022, 48.44.023, 48.46.064, and 48.46.066.

(2) Benefits will be found not to be unreasonable if the projected earned premium for the rate renewal period is equal to the following:

(a) An actuarially sound estimate of incurred claims associated with the filing for the rate renewal period, where the actuarial estimate of claims recognizes, as applicable, the savings and costs associated with managed care provisions of the plans included in the filing; plus

(b) An actuarially sound estimate of prudently incurred expenses associated with the plans included in the filing for the rate renewal period, where the estimate is based on an equitable and consistent expense allocation or assignment methodology; plus

(c) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges, where the justification recognizes the carrier's investment earnings on assets other than those related to claim reserves or other similar liabilities; minus

(d) An actuarially sound estimate of the forecasted investment earnings on assets related to claim reserves or other similar liabilities for the plans included in the filing for the rate renewal period.

(3) The contribution to surplus, contingency charges, or risk charges in subsection (2)(c) of this section, will not be required to be less than zero.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-915, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-915, filed 1/23/98, effective 3/1/98.]

WAC 284-43-920 When a carrier is required to file.

(1) Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule:

(a) Before the contract form is offered for sale to the public and before the rate schedule is used; and

(b) Within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.

(2) Filings of negotiated contract forms, and applicable rate schedules, that are placed into effect at time of negotiation or that have a retroactive effective date are not required to be filed in accordance with subsection (1)(a) and (b) of this section, but must be filed within thirty working days after the earlier of:

(a) The date group contract negotiations are completed; or

(b) The date renewal premiums are implemented.

(3) An explanation for any filing delayed beyond the thirty-day period as described in subsection (2) of this section

must be given on the filing document as set forth in WAC 284-43-950.

(4) If written confirmation of the commissioner's final action is desired, the carrier must submit with the filing duplicate copies of the filing transmittal and cover letter, along with a return self-addressed, stamped envelope. The duplicate transmittal will note the commissioner's final action and will be returned to the sender in the return envelope enclosed with the filing.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-920, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-920, filed 1/23/98, effective 3/1/98.]

WAC 284-43-925 General contents of all filings. Each filing required by WAC 284-43-920 must be submitted with the filing transmittal form prescribed by and available from the commissioner. The form must include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information. Filings also must include the information required on the filing summary set forth in WAC 284-43-945 for individual and small group plans and rate schedules or as set forth in WAC 284-43-950 for group plans and rate schedules other than those for small groups.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-925, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-925, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-925, filed 1/23/98, effective 3/1/98.]

WAC 284-43-930 Contents of individual and small group filings. Under RCW 48.44.022 and 48.46.064 the experience of all individual plans must be pooled. Under RCW 48.44.023 and 48.46.066 the experience of all small group plans must be pooled. Filings for individual plans must include each individual plan rate schedule. Filings for small group plans must include base rates and annual base rate changes in dollar and percentage amounts for each small group plan. Each individual and small group filing must include the following information and documents:

(1) An actuarially sound estimate of incurred claims. Experience data, assumptions, and justifications of the carrier's projected incurred claims must be provided in a manner consistent with the carrier's rate-making methodology and incorporate the following elements:

(a) A brief description of the carrier's rate-making methodology, including identification of the data used and the kinds of assumptions and projections made.

(b) The number of subscribers by family size, or covered persons for the plans included in the filing. These figures must be shown for each month or quarter of the experience period and the prior two periods if not included in previous filings. This data must be presented in aggregate for the plans included in the filing and in aggregate for all of the carrier's plans.

(c) Earned premium for each month or quarter of the experience period and the prior two periods if not included in previous filings, for the plans included in the filing.

(d) An estimate of the adjusted earned premium for each month or quarter of the experience period and prior two periods for the plans included in the filing.

(e) Claims data for each month or quarter of the experience period and the prior two periods. Examples of claims data are incurred claims, capitation payments, utilization data, unit cost data, and staffing data. The specific data elements included in the filing must be consistent with the carrier's rate-making methodology.

(f) Documentation and justification of any adjustments made to the experience data.

(g) Documentation and justification of the factors and methods used to forecast incurred claims.

(2) An actuarially sound estimate of prudently incurred expenses. Experience data, assumptions, and justifications must be provided by the carrier as follows:

(a) A breakdown of the carrier's expenses allocated or assigned to the plans included in the filing for the experience period or for the period corresponding to the most recent "annual statement";

(i) An expense breakdown at least as detailed as the annual statement schedule "Underwriting and Investment Exhibit, Part 3, Analysis of Expenses" as revised from time to time;

(ii) The allocation and assignment methodology used in (a)(i) of this subsection may be based on readily available data and easily applied calculations;

(b) Identification of any extraordinary experience period expenses; and

(c) Documentation and justification of the assignment or allocation of expenses to the plans included in the filing; and

(d) Documentation and justification of forecasted changes in expenses.

(3) An actuarially sound provision for contribution to surplus, contingency charges, or risk charges. Assumptions and justifications must be provided by the carrier as follows:

(a) The methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates; and

(b) The carrier's net worth or reserves and unassigned surplus at the beginning and end of the experience period.

(4) An actuarially sound estimate of forecasted investment earnings on assets related to claim reserves or other similar liabilities. The carrier must include documentation and justification of forecasted investment earnings identified in dollars, and as a percentage of total premiums and the amount credited to the plans included in the filing.

(5) Adjustment of the base rate. Experience data, assumptions, justifications, and methodology descriptions must be provided and must include:

(a) Justifications for adjustments to the base rate, supported by data if appropriate, attributable to geographic region, age, family size, tenure discounts, and wellness activities;

(b) Justifications, supported by data if appropriate, of any other factors or circumstances used to adjust the base rates; and

(c) Description of the methodology used to adjust the base rate to obtain the premium rate for a specific individual or group, which is detailed enough to allow the commissioner to replicate the calculation of premium rates if given the necessary data.

(6) Actuarial certification. Certification by an actuary, as required by RCW 48.44.017(2), 48.44.023(3), 48.46.062(2) and 48.46.066(3).

(7) The requirements of subsections (1) through (6) of this section may be waived or modified upon the finding by the commissioner that a plan contains or involves unique provisions or circumstances and that the requirements represent an extraordinary administrative burden on the carrier.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-930, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-930, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060 and 48.92.140. 98-11-089 (Matter No. R 98-8), § 284-43-930, filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-930, filed 1/23/98, effective 3/1/98.]

WAC 284-43-935 Experience records. (1) For each plan, carriers must maintain the following records for five years:

(a) Incurred claims;

(b) Earned premiums; and

(c) Expenses.

(2) Such records must include data for rider and endorsement forms that are used with the contract forms. Separate data may be maintained for each rider or endorsement form as appropriate. For recordkeeping purposes, carriers may combine experience under contract forms that provide substantially similar coverage.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-935, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-935, filed 1/23/98, effective 3/1/98.]

WAC 284-43-940 Evaluating experience data. In determining the credibility and appropriateness of experience data, consideration will be given to all relevant factors, including:

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

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

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

(4) Adverse selection or lapse factors reasonably expected in connection with revisions to plan provisions, services, benefits, and amount charged.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-940, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-940, filed 1/23/98, effective 3/1/98.]

WAC 284-43-945 Summary for individual and small group contract filings.

INDIVIDUAL AND SMALL GROUP FILING SUMMARY

Carrier Name _____
Address _____

Carrier Identification Number _____

Rate Renewal Period: _____	From _____	To _____
Date Submitted: _____		

Proposed Rate Summary

Current community rate _____	per month
Proposed community rate _____	per month
Percentage change _____	%
Portion of carrier's total enrollment affected _____	%
Portion of carrier's total premium revenue affected _____	%

Components of Proposed Community Rate

	Dollars Per Month	% of Total
a) Claims		
b) Expenses		
c) Contribution to surplus, contingency charges, or risk charges		
d) Investment earnings		
e) Total (a + b + c - d)		

Summary of Pooled Experience

	Experience Period From To	First Prior Period From To	Second Prior Period From To
Member Months			
Earned Premium			
Paid Claims			
Beginning Claim Reserve			
Ending Claim Reserve			
Incurred Claims			
Expenses			
Gain/Loss			
Loss Ratio Percentage			

General Information

1. Trend Factor Summary

Type of Service	Annual Trend Assumed	Portion of Claim Dollars
Hospital	%	%
Professional	%	%
Prescription Drugs	%	%
Dental	%	%
Other	%	%

2. List the effective date and the rate of increase for all rate changes in the past three rate periods.

1) _____ Date % 2) _____ Date % 3) _____ Date %

3. Since the previous filing, have any changes been made to the factors or methodology for adjusting base rates?

- Geographic Area Yes No
- Family Size Yes No
- Age Yes No
- Wellness Activities Yes No

Other (specify) Yes No

4. Attach a table showing the base rate for each plan affected by this filing.

5. Attach comments or additional information.

6. Preparer's Information

Name: _____

Title: _____

Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 08-20-071 (Matter No. R 2008-08), § 284-43-945, filed 9/25/08, effective 10/26/08. Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-945, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-945, filed 1/23/98, effective 3/1/98.]

WAC 284-43-950 Summary for group contract filings other than small group contract filings.

GROUPS OTHER THAN SMALL GROUPS FILING SUMMARY

Carrier Name _____	
Address _____	

Contract Holder/Pool Category and Name (Check One Box)	<input type="checkbox"/> Single Employer Group: Employer Name: _____
	<input type="checkbox"/> Multiemployer other than Association/Trust Groups Group Pool Name: _____
	<input type="checkbox"/> Association/Trust Groups Association/Trust Group Name: _____
Contract Form Number _____	
Rate Form Number (if different from Contract Form Number) _____	
Product Name _____	

If additional space is required to list the contract/rate form number and product name, attach a separate sheet.

Rate Renewal Period: _____	From: _____	To: _____
Date Submitted: _____		
Type of Filing (Check One Box)	<input type="checkbox"/> New Group Contract	<input type="checkbox"/> Revision of Existing Group Contract

Proposed Rate Schedules: Attach a separate sheet to list all proposed tier rates.

Rate Summary

Current Rate (Composite per employee or per member)	\$ _____ per member per month
Percentage Rate Change	_____ %
New Rate	\$ _____ per member per month
Average Number of Enrollees Each Month During the Experience Period (If the average number of enrollees is equal to or less than fifty, explain why this is not a small group, as defined in RCW 48.43.005.)	_____
Anticipated Loss Ratio	_____ %
Portion of carrier's total enrollment affected	_____ %
Portion of carrier's total premium revenue affected	_____ %

Summary of Contract Experience

	Experience Period From To	First Prior Period From To	Second Prior Period From To
Member Months			
Billed Premium			
Incurred Claims			
Expenses			
Gain/Loss			
Experience Refund/Credit or Recoupment			
Earned Premium (Billed Premium - /+ Refund/Credit or Recoupment)			
Loss Ratio Percentage			

Attach comments or additional information.
Preparer's Information
Name: _____
Title: _____
Telephone Number: _____

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 05-07-006 (Matter No. R 2004-05), § 284-43-950, filed 3/3/05, effective 4/3/05. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. 98-04-011 (Matter No. R 97-2), § 284-43-950, filed 1/23/98, effective 3/1/98.]

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.
- 284-44-250 Accounting method.
- 284-44-300 Purpose and applicability.
- 284-44-310 Agreement underwritten by insurance.
- 284-44-320 Agreement guaranteed by a surety company.
- 284-44-330 Agreement guaranteed by a deposit of cash or securities.
- 284-44-340 Modification of amount of reimbursement or indemnity.
- 284-44-350 Records and reporting.
- 284-44-450 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.
- 284-44-100 Authority and purpose. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-100, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-

- 284-44-110 011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066. Applicability and scope. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-110, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-120 Definitions. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-120, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-130 When filing is required. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-130, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-140 General contents of all filings. [Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21.-045(2), 48.29.140, 48.43.055, 48.44.023(2), 48.44.040, 48.44.070, 48.46.030, 48.46.060, 48.46.066(2), 48.46.-243, 48.96.025, 48.102.020. 96-11-004 (Matter No. R 96-1), § 284-44-140, filed 5/2/96, effective 6/2/96. Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-140, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-150 Experience records. [Statutory Authority: RCW 48.44.-050. 81-15-070 (Order R 81-3), § 284-44-150, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-160 Evaluating experience data. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-160, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-170 Minimum required 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.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.-060.
- 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.
- 284-44-190 Unique contract forms. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-190, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-200 Effective date. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-200, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-210 "Filing document" form—Standard contract filing information. [Statutory Authority: RCW 48.44.050. 81-15-070 (Order R 81-3), § 284-44-210, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority:

- RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-220 "Filing document" form—Nonstandard contract filing information. [Statutory Authority: RCW 48.44.050, 81-15-070 (Order R 81-3), § 284-44-220, filed 7/21/81, effective 10/1/81.] Repealed by 98-04-011 (Matter No. R 97-2), filed 1/23/98, effective 3/1/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.44.020 (2)(d), 48.44.022, 48.44.023, 48.46.060 (3)(d) and (5), 48.46.064 and 48.46.066.
- 284-44-240 Participating provider contracts. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060 (2), 48.46.200 and 48.46.243.
- 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. [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.] Repealed by 96-17-079 (Matter No. R 95-18), filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
- 284-44-360 Effective date. [Statutory Authority: RCW 48.44.050, 82-23-010 (Order R 82-6), § 284-44-360, filed 11/5/82, effective 1/1/83.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
- 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.
- 284-44-410 Form for reporting number of persons entitled to services. [Statutory Authority: RCW 48.44.050, 84-08-001 (Order R 84-1), § 284-44-410, filed 3/22/84.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243.

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 sub-captions.

(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, med-

ical 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.

(5) Whenever a covered person appeals the health care service contractor's decision and delay would jeopardize the covered person's life or health, the health care service contractor must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-44-043, filed 11/29/99, effective 12/30/99. 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 agree-

ment 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 284-44-250 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.

[Title 284 WAC—p. 250]

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-250, filed 11/5/82, effective 1/1/83.]

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

(2) This regulation applies to every health care service contractor registered pursuant to chapter 48.44 RCW.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-300, filed 11/5/82, effective 1/1/83.]

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

(a) Have a continuous term;

(b) Fully insure the benefits of the persons who have paid for or contracted for covered health care services, which persons shall be designated as beneficiaries, when such services are not performed by the health care service contractor or a participant;

(c) Contain a provision that, in the event of cancellation, the coverage shall continue with respect to services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled without ninety days advance written notice to the insured or insurer by the cancelling party; and

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the insurer of any cancellation.

(2) The original or a true copy of the actual insurance contract or policy shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-310, filed 11/5/82, effective 1/1/83.]

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

(a) Be in an amount equal to the greater of (i) one hundred fifty thousand dollars, or (ii) one-twelfth of the total sum of money received during the preceding calendar year as prepayment for health care services, except as provided by WAC 284-44-340;

(b) Contain a provision that the bond will be for the benefit of the persons who have paid for or contracted for the health care services;

(c) Contain a provision that in the event of cancellation, the bond will continue to cover liabilities for services provided prior to the effective date of such cancellation;

(d) Contain a provision that it may not be cancelled or terminated without ninety days advance written notice to the assured or surety company by the cancelling party;

(e) Contain a provision requiring not less than sixty days advance notice to the insurance commissioner, health care services division, by the surety company of any cancellation of such surety agreement.

(2) The original or a true copy of the actual surety bond shall be filed with the insurance commissioner, health care services division, prior to its effective date.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-320, filed 11/5/82, effective 1/1/83.]

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

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

(3) In determining the value to be assigned to securities for compliance with the depository requirements, market value shall be the measurement.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-330, filed 11/5/82, effective 1/1/83.]

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

- (a) The overall adequacy of the contractor's reserves for future benefits;
- (b) The relationship between indemnity claims and claims covered by contractual agreements with providers;
- (c) The overall financial stability of the contractor; and
- (d) A reasonable projection of any increase or decrease of such benefits.

(2) The commissioner may from time to time require additional indemnification to be furnished when a review of the health care service contractor's affairs demonstrates that existing indemnification is inadequate.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-340, filed 11/5/82, effective 1/1/83.]

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

shall be obtained, and shall be deposited with, or evidenced to, the commissioner within thirty days of the filing of the report.

(2) A health care service contractor using either a policy of insurance or a surety bond to provide for indemnification shall notify the insurance commissioner, health care services division, sixty days in advance of termination or cancellation of the contract or policy of insurance or surety bond.

[Statutory Authority: RCW 48.44.050. 82-23-010 (Order R 82-6), § 284-44-350, filed 11/5/82, effective 1/1/83.]

WAC 284-44-450 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.

[Title 284 WAC—p. 252]

(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

284-46-025	General contents of all rate or forms of contract filings.
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.

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.
284-46-020	Form for reporting number of persons entitled to services. [Statutory Authority: RCW 48.46.200. 84-08-002 (Order R 84-2), § 284-46-020, filed 3/22/84.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.-200 and 48.46.243.
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. [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.] Repealed by 96-17-079 (Matter No. R 95-18), filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200.
284-46-575	Participating provider contracts. [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.] Repealed by 98-04-005 (Matter No. R 97-3), filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.-060(2), 48.46.200 and 48.46.243.

WAC 284-46-025 General contents of all rate or forms of contract filings. Each filing made of a rate or con-

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tract form shall be submitted with the filing transmittal form prescribed by and available from the commissioner. Use of a standardized transmittal form makes it easier for the commissioner to identify filings, issuers, and other important identifying information; permits more efficient tracking of filings; and makes it less difficult to provide status reports of filings to persons outside the office. The form will include the name of the filing entity, its address, identification number, the type of filing being submitted, the form name or group name and number, and other relevant information.

[Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21.045(2), 48.29.140, 48.43.055, 48.44.023(2), 48.44.040, 48.44.070, 48.46.030, 48.46.060, 48.46.066(2), 48.46.243, 48.96.025, 48.102.020. 96-11-004 (Matter No. R 96-1), § 284-46-025, filed 5/2/96, effective 6/2/96.]

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

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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

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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:

mandibular 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.

(5) Whenever a covered person appeals the decision of the health maintenance organization and delay would jeopardize the covered person's life or health, the health maintenance organization must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-46-507, filed 11/29/99, effective 12/30/99. 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.]

**Chapter 284-48 WAC
BULLETINS**

WAC

284-48-010 License status of creditors under credit group policies—Commissions.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

284-48-020 Authority of agents v. brokers: (1) Brokers of record, (2) marketing substandard auto, (3) rejected life and disability. [Filed May 18, 1966.] Repealed by 95-20-022 (Order R 95-8), filed 9/26/95, effective 10/27/95. Statutory Authority: RCW 48.02.060.

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 compensa-

tion 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.]

Chapter 284-49 WAC

WASHINGTON BASIC COVERAGE POLICY (SMALL GROUP) INSURANCE REGULATION

WAC

284-49-010 Reservation of chapter.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 284-49-020 Supplanting or superseding of existing policies. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.-110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-050 Definitions. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-100 Forms—prior approval. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-115 General contents of form and rate filings. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.-110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-300 Minimum policy requirements. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-330 Minimum coverage. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-500 Standards for loss ratios. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-510 Filing requirements. [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.] Repealed by 05-02-074 (Matter No.

- 284-49-520 R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-900 Experience records. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.
- 284-49-999 Collection of data and reporting. [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.] Repealed by 05-02-074 (Matter No. R 2004-07), filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200.

WAC 284-49-010 Reservation of chapter. Chapter 284-49 WAC is reserved for future small group health regulations.

[Statutory Authority: RCW 48.02.060, 48.18.110, 48.44.020, 48.44.050, 48.46.060, 48.46.200. 05-02-074 (Matter No. R 2004-07), § 284-49-010, filed 1/4/05, effective 2/4/05. 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.]

**Chapter 284-50 WAC
WASHINGTON DISABILITY INSURANCE REGULATIONS**

WAC

ADVERTISING

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284-50-390	Basic medical-surgical expense coverage, outline of coverage.
284-50-395	Basic hospital and medical surgical expense coverage, outline of coverage.
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.
284-50-440	Standard disclosure form for individual policies—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-50-435	Separability. [Order R-76-4, § 284-50-435, filed 10/29/76, effective 3/1/77.] Repealed by 98-11-088 (Matter No. R 98-5), filed 5/20/98, effective 6/20/98. Statutory Authority: RCW 48.02.060.
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 pre-

mium, 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 (2009 Ed.)

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.]

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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

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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.]

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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.]

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

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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.

[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).

(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

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(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

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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, 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 dis-

abled 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 liabil-

ity 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 pay-

ment 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;

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(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.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the insurer must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-50-377, filed 11/29/99, effective 12/30/99. 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 copayment 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 copayment 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 copayment 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 copayment 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.

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(COMPANY NAME)

BASIC HOSPITAL AND MEDICAL SURGICAL EXPENSE COVERAGE
AGE

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 copayment 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 copayment 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!**

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(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, copayment 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;

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- (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 copayment 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

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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 copayment 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 copayment 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.)

(2009 Ed.)

(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 copayment 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.

[Title 284 WAC—p. 275]

(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, (pre-existing 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, (pre-existing 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 284-50-440 Standard disclosure form for individual policies—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance.

(1) All disability insurers offering individual policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to all applicants at the time of solicitation and completion of the application form for coverage. Every insurer must have a mechanism in place to verify delivery of the disclosure to the applicant.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed for approval with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address) IMPORTANT INFORMATION ABOUT THE COVERAGE 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 fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure document provides a very brief description of the important features of the coverage you are considering. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in

detail the rights and obligations of both you and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), before you purchase this policy you should check with your tax advisor to be sure that you will continue to be eligible to contribute to the HSA if you purchase this coverage.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):

- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370. 07-21-073 (Matter No. R 2007-05), § 284-50-440, filed 10/15/07, effective 11/15/07.]

Chapter 284-51 WAC

STANDARDS FOR COORDINATION OF BENEFITS

WAC

284-51-190	Purpose.
284-51-195	Definitions.
284-51-200	Use of model COB contract provision.
284-51-205	Rules for coordination of benefits.
284-51-210	Coordination procedures.
284-51-215	Time limit.
284-51-220	Facility of payment.
284-51-225	Right of recovery.
284-51-230	Procedure to be followed by secondary plan to calculate benefits and pay a claim.
284-51-235	Notice to covered persons.
284-51-240	Small claim waivers.
284-51-245	Miscellaneous provisions.
284-51-250	Applicability and scope—Effective date for existing contracts.
284-51-255	Appendix A—Model COB contract provisions.
284-51-260	Appendix B—Consumer explanatory booklet.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-51-010	Purpose and scope. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-015	Amount of reduction allowed. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07.

284-51-020	Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. Required provisions for coordination of 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), § 284-51-020, 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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-030	Benefits subject to coordination. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-040	"Plan" defined. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-045	"Preventive care" defined. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-050	Allowable expense. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-060	Claim determination period. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
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).
284-51-075	Order of benefit determination. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-080	Determination of length of coverage. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.

- 284-51-090 Coordination procedures. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. filed 11/4/86, effective 1/1/87.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-100 Time limit. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-110 Small claim waivers. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-120 Facility of payment. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-130 Right of recovery. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-140 Right to receive and release necessary information. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-150 Disclosure of coordination. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 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).
- 284-51-170 Effective date. [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.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-180 Appendix A, form for "effect on benefits" provision. [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.] Repealed by 98-09-041 (Matter R 98-01), filed 4/14/98, effective 5/15/98. Statutory Authority: RCW 48.02.060, 48.17.150, 48.44.040, 48.46.200 and 48.44.050.
- 284-51-185 Appendix B, form for "effect on benefits" provision. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-185,

WAC 284-51-190 Purpose. (1) The purpose of this chapter is to:

(a) Establish a uniform order of benefit determination under which plans pay claims;

(b) Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, under rules established by this chapter, do not have to pay their benefits first; and

(c) Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

(2) This chapter does not require the use of coordination of benefits provisions in a plan. However, if a plan contains any provision for the reduction of benefits payable because of other insurance, it must be consistent with the requirements of this chapter. A plan of coverage designed to be supplementary over the underlying basic plan of coverage may provide coverage that is excess to the basic plan of coverage.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-190, filed 6/8/07, effective 7/9/07.]

WAC 284-51-195 Definitions. As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Allowable expense," except as outlined below means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When medicare, Part A and Part B or Part C are primary, medicare's allowable amount is the highest allowable expense.

(a) If an issuer is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.

(b) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(c) The following are examples of expenses that are not allowable expenses:

(i) If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(ii) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other

similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(iii) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense must include similar expenses to which COB applies.

(e) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(2) "Birthday" refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(3) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- (a) Services (including supplies);
- (b) Payment for all or a portion of the expenses incurred;
- (c) A combination of (a) and (b) of this subsection; or
- (d) An indemnification.

(4) "Claim determination period" means calendar year.

(5) "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation according to federal law.

(7) "Coordination of benefits" or "COB" means a provision establishing the order that plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(8) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation; or

(c) In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10)(a) "Hospital indemnity benefits" or "hospital fixed payment plan" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" or "hospital fixed payment plan" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(11) "Issuer" means a disability carrier, health care service contractor, health maintenance organization, and any other entity issuing a plan as defined in this chapter.

(12) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(a) If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection.

(b) "Plan" includes:

(i) Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers as defined in this chapter;

(ii) Closed panel plans or other forms of group or individual coverage;

(iii) The medical care components of long-term care contracts, such as skilled nursing care; and

(iv) Medicare or other governmental benefits, as permitted by law, except as provided in (c)(vii) of this subsection. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(c) "Plan" does not include:

(i) Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;

(ii) Accident only coverage;

(iii) Specified disease or specified accident coverage;

(iv) Limited benefit health coverage, as defined in WAC 284-50-370;

(v) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(vi) Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vii) Medicare supplement policies;

(viii) A state plan under medicaid;

(ix) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;

(x) Automobile insurance policies required by statute to provide medical benefits;

(xi) Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined in section 3, chapter 267, Laws of 2007.

(13) "Policyholder" means the primary insured named in a nongroup insurance policy.

(14) "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan subject to this chapter is a primary plan if:

(a) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

(b) All plans that cover the person use the order of benefit determination rules required by this chapter, and under those rules the plan determines its benefits first.

(15) "Secondary plan" means a plan that is not a primary plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-195, filed 6/8/07, effective 7/9/07.]

WAC 284-51-200 Use of model COB contract provision. (1) WAC 284-51-255, Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of subsections (2), (3), and (4) of this section and to the provisions of this chapter.

(2) WAC 284-51-260, Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are in the contract. Its purpose is to explain the process to be used by two or more plans to pay for or provide benefits as allowed by the provisions of this chapter.

(3) Issuers need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in WAC 284-51-260. Editing changes may be made by the issuer to fit the language and style of the rest of its contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. Modifications may be made provided they do not conflict with the requirements of this chapter.

(4) A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person could have been covered under another plan; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

(5) No plan may contain a provision that its benefits are "always excess" or "always secondary" except under the rules permitted in this chapter.

(6) No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in this chapter.

(7) If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. Further, coordination of benefits may occur during the claim determination period even where there are no savings in the closed panel plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-200, filed 6/8/07, effective 7/9/07.]

WAC 284-51-205 Rules for coordination of benefits.

(1) When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

(b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(c) When multiple contracts providing coordinated coverage are treated as a single plan under this chapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with this chapter.

(d) If a person is covered by more than one secondary plan, the order of benefit determination rules of this chapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this chapter, has its benefits determined before those of that secondary plan.

(2)(a) Except as provided in (b) of this subsection, a plan that does not contain order of benefit determination provisions that are consistent with this chapter is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this chapter, it is secondary to that other plan.

(4) Order of benefit determination. Each plan determines its order of benefits using the first of the following rules that applies:

(a) Nondependent or dependent.

(i) Subject to (a)(ii) of this subsection, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(ii)(A) If the person is a medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g., a retired employee);

(B) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:

(i) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(A) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;

(B) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(C) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (b)(i) of this subsection determine the order of benefits;

(D) If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (b)(i) of this subsection determine the order of benefits; or

(E) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:

(I) The plan covering the custodial parent, first;

(II) The plan covering the custodial parent's spouse, second;

(III) The plan covering the noncustodial parent, third; and then

(IV) The plan covering the noncustodial parent's spouse, last.

(iii) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable, under (b)(i) or (ii) of this subsection as if those individuals were parents of the child.

(c) Active employee or retired or laid-off employee.

(i) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(ii) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(d) COBRA or state continuation coverage.

(i) If a person whose coverage is provided under COBRA or under a right of continuation according to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan.

(ii) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(e) Longer or shorter length of coverage.

(i) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(ii) To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended.

(iii) The start of a new plan does not include:

(A) A change in the amount or scope of a plan's benefits;

(B) A change in the entity that pays, provides or administers the plan's benefits; or

(C) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(iv) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date to determine the length of time the person's coverage under the present plan has been in force.

(f) If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-205, filed 6/8/07, effective 7/9/07.]

WAC 284-51-210 Coordination procedures. Issuers must use the following claims administration practices to expedite claim payments where coordination of benefits is involved:

(1) Claim personnel must participate in continuing education programs.

(2) All requests for information must be handled in an accurate and prompt manner by the inquiring issuer and the responding issuer, including the disclosure of the amounts allowed and paid or to be paid by the primary plan for each claim.

(3) Claim personnel of all issuers, whether primary or secondary, must make every reasonable effort, including use of the telephone or e-mail, to speed up exchange of coordination of benefits information. Delay of payment for lack of complete coordination of benefits information does not constitute a reasonable effort and compliance with WAC 284-51-215 is required.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-210, filed 6/8/07, effective 7/9/07.]

WAC 284-51-215 Time limit. Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-43-321. Any time limit established by a secondary plan that is in excess of ninety days from receipt of a claim will be considered unreasonable. When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit to make payment as the primary plan because it has insufficient information to make it a secondary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. Any issuer that is knowingly responsible for payment as the secondary plan must make a reasonable estimate of the primary plan payment and base its secondary payment on that amount. After payment information is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-215, filed 6/8/07, effective 7/9/07.]

WAC 284-51-220 Facility of payment. A plan providing for coordination of benefits must contain a "facility of payment" provision substantially as follows: "If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan."

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-220, filed 6/8/07, effective 7/9/07.]

WAC 284-51-225 Right of recovery. A plan providing for coordination of benefits must contain a "right of recovery" provision substantially as follows: "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer

may recover excess payment from any person, other issuer or plan that has received payment.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-225, filed 6/8/07, effective 7/9/07.]

WAC 284-51-230 Procedure to be followed by secondary plan to calculate benefits and pay a claim. (1) In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary carrier be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the enrollee be responsible for a deductible amount greater than the highest of the two deductibles.

(2) If a plan by its terms contains gatekeeper requirements as defined in subsection (3) of this section, and a person fails to comply with such requirements, these provisions will have the following effect in the absence of an alternative procedure agreed upon between both plans and the covered person:

(a) If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.

(b) If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network.

(3) For the purpose of this section, "gatekeeper requirements" means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. These requirements include but are not limited to use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.

(4) When a plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings are recorded as a benefit reserve for the covered person and must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the issuer of the secondary plan must:

(a) Determine its obligation under its plan;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

(d) Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-230, filed 6/8/07, effective 7/9/07.]

WAC 284-51-235 Notice to covered persons. A plan must include the following statement in the enrollee contract or booklet provided to covered persons: "If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If medicare is your primary plan, medicare may submit your claims to your secondary carrier for you."

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-235, filed 6/8/07, effective 7/9/07.]

WAC 284-51-240 Small claim waivers. In appropriate cases, issuers are encouraged to waive the investigation of possible other plan coverage on claims less than fifty dollars. However, if additional liability is incurred which raises the claim above fifty dollars, the entire liability may be included in the coordination of benefits computation.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-240, filed 6/8/07, effective 7/9/07.]

WAC 284-51-245 Miscellaneous provisions. (1) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision requires a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

(2)(a) A plan with order of benefit determination rules that comply with this chapter (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this chapter (non-complying plan) on the following basis:

(i) If the complying plan is the primary plan, it must pay or provide its benefits first;

(ii) If the complying plan is the secondary plan under the order of benefit determination in this chapter, it must pay or provide its benefits first, but the amount of the benefits payable must be determined as if the complying plan were the secondary plan. In this situation, the payment is the limit of the complying plan's liability; and

(iii) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans.

(b) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncom-

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plying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference.

(c) In no event may the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

(3) COB differs from subrogation. Provisions for one may be included in plans without compelling the inclusion or exclusion of the other.

(4) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received the information needed to pay the claim, the plans must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-245, filed 6/8/07, effective 7/9/07.]

WAC 284-51-250 Applicability and scope—Effective date for existing contracts. This chapter applies to all plans, as defined in WAC 284-51-195 that are issued, amended or renewed after December 31, 2007. All plans issued prior to January 1, 2008 must be compliant with this chapter on that date.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-250, filed 6/8/07, effective 7/9/07.]

WAC 284-51-255 Appendix A—Model COB contract provisions.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The coordination of benefits (COB) provision applies when a person has health care coverage under more than one **plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **plan** will pay a claim for benefits. The **plan** that pays first is called the **primary plan**. The **primary plan** must pay benefits according to its policy terms without regard to the possibility that another **plan** may cover some expenses. The **plan** that pays after the **primary plan** is the **secondary plan**. The **secondary plan** may reduce the benefits it pays so that payments from all **plans** do not exceed 100% of the total **allowable expense**.

DEFINITIONS

A. A **plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or

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to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; medicare supplement policies; medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **plan**. If a **plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **this plan** is a **primary plan** or **secondary plan** when the person has health care coverage under more than one **plan**.

When **this plan** is primary, it determines payment for its benefits first before those of any other **plan** without considering any other **plan's** benefits. When **this plan** is secondary, it determines its benefits after those of another **plan** and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the **total allowable expense** for that claim. This means that when this **plan** is **secondary**, it must pay the amount which, when combined with what the **primary plan** paid, totals 100% of the highest **allowable expense**. In addition, if this **plan** is **secondary**, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **allowable expense** under this **plan**. If this **plan** is **secondary**, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **plan** covering the person. When a **plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **allowable**

expense and a benefit paid. An expense that is not covered by any **plan** covering the person is not an **allowable expense**.

The following are examples of expenses that are not **allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **allowable expense**, unless one of the **plans** provides coverage for private hospital room expenses.

(2) If a person is covered by two or more **plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **allowable expense**.

(3) If a person is covered by two or more **plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **allowable expense**.

E. **Closed panel plan** is a **plan** that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the **plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **plans**, the rules for determining the order of benefit payments are as follows:

A. The **primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **plan**.

B. (1) Except as provided in subsection (2), a **plan** that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both **plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the **plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.

C. A **plan** may consider the benefits paid or provided by another **plan** in calculating payment of its benefits only when it is secondary to that other **plan**.

D. Each **plan** determines its order of benefits using the first of the following rules that apply:

(1) Nondependent or dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **primary plan** and the **plan** that covers the person as a dependent is the **secondary plan**. However, if the person is a medicare beneficiary and, as a result of federal law, medicare is secondary to the **plan** covering the person as a dependent,

and primary to the **plan** covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **secondary plan** and the other **plan** is the **primary plan**.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **plan** of the parent whose birthday falls earlier in the calendar year is the **primary plan**; or
- If both parents have the same birthday, the **plan** that has covered the parent the longest is the **primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. This rule applies to claim determination periods commencing after the **plan** is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **plan** covering the **custodial parent**, first;
- The **plan** covering the spouse of the **custodial parent**, second;
- The **plan** covering the **noncustodial parent**, third; and then
- The **plan** covering the spouse of the **noncustodial parent**, last

(c) For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The **plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **primary plan**. The **plan** covering that same person as a retired or laid-off employee is the **secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

(2009 Ed.)

If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **primary plan** and the COBRA or state or other federal continuation coverage is the **secondary plan**. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **primary plan** and the **plan** that covered the person the shorter period of time is the **secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **allowable expenses** must be shared equally between the **plans** meeting the definition of **plan**. In addition, **this plan** will not pay more than it would have paid had it been the **primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

When **this plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a claim determination period are not more than the total **allowable expenses**. In determining the amount to be paid for any claim, the **secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **allowable expense** for that claim **total allowable expense** is the highest **allowable expense** of the **primary plan** or the **secondary plan**. In addition, the **secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **this plan** and other **plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **this plan** and other **plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **this plan** must give [organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **this plan** are made by another **plan**, the issuer has the right, at its dis-

cretion, to remit to the other **plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **plan** are considered benefits paid under **this plan**. To the extent of such payments, the issuer is fully discharged from liability under **this plan**.

RIGHT OF RECOVERY

The issuer has the right to recover excess payment when- ever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any per- son to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits? Contact Your State Insurance Department

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-255, filed 6/8/07, effective 7/9/07.]

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

WAC 284-51-260 Appendix B—Consumer explana- tory booklet.

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the lan- guage contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family cov- erage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coor- dination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and cov- ers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to deter- mine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

[Title 284 WAC—p. 286]

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by medi- care, and you are not both retired.
- **Your child's expenses.** The claim is for the health care expenses of your child who is covered by this plan; and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make a reasonable estimate of the primary plan payment and base our payment on that amount. After payment information is received from the primary plan, we may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan. We may not delay our pay- ments because of lack of information from the primary plan. We are required to pay claims within ninety days of receipt.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. How- ever, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

- We will determine our payment by subtracting the amount we estimate that the primary plan will pay from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred per- cent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim.

(2009 Ed.)

We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

**Questions About Coordination of Benefits?
Contact Your State Insurance Department**

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-260, filed 6/8/07, effective 7/9/07.]

**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 unin-

sured 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.

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- (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) Alcoholism and drug addiction.
- (2) Pregnancy, except for complications of pregnancy.
- (3) Illness, treatment or medical condition arising out of:
 - (a) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto.
 - (b) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury.
 - (c) Aviation.
 - (4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows covered surgery resulting from trauma, infection or other diseases of the involved part, reconstructive breast surgery covered pursuant to RCW 48.20.395, 48.21.230, 48.44.330 and 48.46.280, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
 - (5) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, or chronic foot strain.
 - (6) Treatment (except emergency treatment for which legal liability exists to the covered person for the costs thereof) provided in a government hospital; benefits provided under medicare or other governmental program (except medicaid), any state or federal worker's compensation, employer's liability or occupational disease law; service rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
 - (7) Dental care or treatment.
 - (8) Eye glasses, hearing aids, and examination for the prescription or fitting thereof.
 - (9) Rest cures, custodial care, transportation, and routine physical examinations.
 - (10) Territorial limitations.
 - (11) Other exclusions commonly used by the particular carrier in group contracts providing hospital or medical benefits to employee groups.

[Statutory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 08-03-126 (Matter No. R 2007-14), § 284-52-070, filed 1/23/08, effective 2/23/08; 84-19-055 (Order R 84-4), § 284-52-070, filed 9/19/84.]

(2009 Ed.)

Chapter 284-53 WAC

STANDARDS FOR COVERAGE OF CHEMICAL
DEPENDENCY

WAC

284-53-005	Definitions.
284-53-010	Standards for coverage of chemical dependency.

WAC 284-53-005 Definitions. (1) "Chronic illnesses" include, but are not limited to, heart disease, diabetes, chronic obstructive pulmonary disease, and chemical dependency.

(2) "Emergency medical condition" has the same meaning as that contained in RCW 48.43.005.

(3) "Medically necessary" or "medical necessity," with respect to chemical dependency coverage, means as indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II* as published in 1996 by the American Society of Addiction Medicine.

[Statutory Authority: RCW 48.02.060, 48.21.197, 48.44.050, and 48.46.200, 04-22-051 (Matter No. R 2003-08), § 284-53-005, filed 10/28/04, effective 11/28/04. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.-200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350, 99-16-005 (Matter No. R 97-8), § 284-53-005, filed 7/22/99, effective 8/22/99.]

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

(1) Medically necessary detoxification must be covered as an emergency medical condition according to RCW 48.43.093, and so long as a patient is not yet enrolled in other chemical dependency treatment, detoxification may not be included when calculating payments within the chemical dependency payment minimum required in this chapter.

(2) Coverage for chemical dependency must provide payment for reasonable charges for any medically necessary treatment and supporting services rendered to an enrollee by a provider that is an "approved treatment program" under RCW 70.96A.020(3). Medically necessary detoxification services may be provided in hospitals licensed under chapter 70.41 RCW.

(3) Except as prohibited by this chapter, chemical dependency coverage may be limited by provisions of the contract that apply to other benefits or services for chronic illnesses or disease including, but not limited to, provisions relating to enrollee point of service cost sharing. Denial of coverage may not be based on contract provisions that are not pertinent to the treatment of chemical dependency, such as provisions requiring a treatment program 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.

(4)(a) The minimum benefit for chemical dependency treatment and supporting services, exclusive of all cost-sharing amounts in any consecutive twenty-four-month period shall be as follows:

(i) For contracts issued or renewed January 1, 2005, through December 31, 2005, the benefit must be no less than twelve thousand five hundred dollars.

(ii) Each succeeding year from January 1, 2006, through December 31, 2009, the benefit must increase in increments of five hundred dollars for new and renewing contracts.

(b) No later than January 1, 2009, the commissioner shall begin a review of past benefit adjustments to determine if increases have been reasonable and to establish future minimum benefits. By June 30, 2009, the commissioner shall publish the new minimum benefit amounts for the period beginning January 1, 2010.

(5) Contracts subject to this rule must comply with the following requirements:

(a) Waiting periods or preexisting condition limitations on chemical dependency coverage may be no more restrictive than those that are imposed for any other chronic illness under the contract.

(b) Reasonable benefits for actual treatment and services rendered may not be denied solely because a course of treatment was interrupted or was not completed.

(c) Coverage may be limited to specific facilities only if the carrier provides or contracts for the provision of approved treatment programs under RCW 70.96A.020 that alone or in combination offer both inpatient and outpatient care and that comply with network adequacy requirements established in WAC 284-43-200. This right to limit coverage to specific facilities permits 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 or is a part of an approved treatment program under RCW 70.96A.020.

(d) A carrier may require prenotification in all reasonable situations, and may require a second opinion if a second opinion is required under the contract for other chronic illnesses. Prenotification with respect to medically necessary detoxification services is not reasonable and may not be required.

(6)(a) In certain circumstances, the carrier may require the enrollee to provide an initial assessment of the need for chemical dependency treatment and a treatment plan prior to scheduled treatment. This will enable the carrier to make its own evaluation of medical necessity. The assessment is at the enrollee's expense and must be provided no less than ten and no more than thirty working days before treatment is to begin. The circumstances are:

(i) Where an enrollee is court ordered to undergo a chemical dependency assessment or treatment;

(ii) Situations related to deferral of prosecution, deferral of sentencing or suspended sentencing; or

(iii) Situations pertaining to motor vehicle driving rights and the Washington state department of licensing.

(b) For the initial assessment in (a) of this subsection, the enrollee may choose any individual that is:

(i) Certified as a chemical dependency professional under chapter 246-811 WAC; and

(ii) Employed by an approved treatment program under chapter 70.96A RCW.

(c) Nothing in this chapter requires a carrier to pay for court ordered chemical dependency treatment that is not medically necessary, or relieves a carrier from its obligations to pay for court ordered chemical dependency treatment when it is medically necessary.

(7) Unless chemical dependency treatment is determined not to be medically necessary, or except as otherwise specif-

ically provided in this chapter, contractual provisions may not restrict access to treatment, continuity of care or payment of claims.

(8) Any contract that provides coverage for chemical dependency must define "chemical dependency" consistent with the definitions contained in Title 48 RCW.

[Statutory Authority: RCW 48.02.060, 48.21.197, 48.44.050, and 48.46.200. 04-22-051 (Matter No. R 2003-08), § 284-53-010, filed 10/28/04, effective 11/28/04. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.-200, 48.21.160, 48.21.180, 48.21.197, 48.44.240 and 48.46.350. 99-16-005 (Matter No. R 97-8), § 284-53-010, filed 7/22/99, effective 8/22/99. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-18-050 (Order R 87-10), § 284-53-010, filed 8/31/87, effective 1/1/88; 86-18-027 (Order R 86-2), § 284-53-010, filed 8/27/86, effective 1/1/87.]

Chapter 284-54 WAC

LONG-TERM CARE INSURANCE RULES

WAC

284-54-010	Purpose and authority.
284-54-015	Applicability and scope.
284-54-020	Definitions of terms used in this chapter and chapter 48.84 RCW.
284-54-030	Standards for definitions applicable to long-term care contracts.
284-54-040	Minimum standards for benefit triggers—Physician certification, activities of daily living, and cognitive impairments.
284-54-050	Exclusions.
284-54-100	Renewability.
284-54-150	Minimum standards—General.
284-54-160	Minimum standards—Gatekeeping provisions.
284-54-180	Reduction of coverage.
284-54-190	Nonduplication with state or national health care benefits.
284-54-200	Prohibition against preexisting conditions and probationary periods in replacement policies or certificates.
284-54-210	Minimum standards for community based care benefits in long-term care insurance policies.
284-54-250	Grace period.
284-54-253	Unintentional lapse.
284-54-260	Extension of benefits.
284-54-270	Requirement to offer inflation protection.
284-54-300	Information to be furnished, style.
284-54-350	Form to be used—Long-term care insurance disclosure form.
284-54-500	Format of long-term care contracts.
284-54-600	Loss ratio requirements.
284-54-610	Loss ratio definitions.
284-54-620	Loss ratio—Grouping of contract forms.
284-54-630	Loss ratio requirements—Individual contract forms.
284-54-650	Loss ratio experience records.
284-54-660	Evaluating loss ratio experience data.
284-54-680	Loss ratio—Special circumstances.
284-54-700	Advertising.
284-54-750	Standards for education of licensees soliciting long-term care contracts.
284-54-800	Unfair or deceptive acts.
284-54-900	Chapter not exclusive.

WAC 284-54-010 Purpose and authority. The purpose of this chapter, is to effectuate chapter 48.84 RCW, the Long-Term Care Insurance Act, by establishing minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care insurance and long-term care benefit policies and contracts issued for delivery in this state before January 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-54-010, filed 11/24/08, effective 12/25/08. 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.

(4) This chapter is applicable only to long-term care policies, contracts, or certificates issued prior to January 1, 2009. Long-term care policies, contracts, or certificates delivered under policies issued on or after January 1, 2009, are governed by chapters 48.83 RCW and 284-83 WAC.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-54-015, filed 11/24/08, effective 12/25/08. 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 including, but not limited to: (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; (f) respite care; (g) adult day health care services; or (h) other similar services furnished in a home-like or residential setting that does not provide overnight care. Such services shall be provided at all levels of care, 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, 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 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-020, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 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 non-acute 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, but not limited to, 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. An insurer may require that services are provided by or under the direction of a home health care agency or home care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(10) "Home health care" shall mean, but is not limited to, any of the following health or medical services: Nursing ser-

vices, home health aide services, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical or social services, and medical supplies or equipment services. An insurer may require that services are provided by or under the direction of a regulated home health care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

(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, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-030, filed 9/11/95, effective 10/12/95. 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 284-54-040 Minimum standards for benefit triggers—Physician certification, activities of daily living, and cognitive impairments.

(1)(a) Except as provided in (b) of this subsection, every long-term care insurance contract or certificate issued on or after January 1, 1996, which provides coverage to a resident of this state, shall require certification by the insured's attending physician that the services are appropriate due to illness or infirmity, or include provisions which condition the payment of benefits on an assessment of the insured's ability to perform specific activities of daily living or the insured's cognitive impairment.

(b) Certificates issued on or after January 1, 1996, under a group long-term care insurance contract that was in force on December 31, 1995, need not meet the standards of this section.

(2) Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the contract or certificate in a separate paragraph labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall be explained in that section. If a trigger differs for different benefits, an explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, the policy shall so specify.

(3) Eligibility for the payment of benefits based on the inability of the insured to perform certain activities shall not be more restrictive than requiring a deficiency in the ability to perform not more than three of the following activities of daily living.

(a) "Activities of daily living" on which an insurer intends to rely as a measure of functional incapacity shall be defined in the policy, and shall include at least all of the following:

(i) Bathing: The ability of the insured to wash himself or herself either in the tub or shower or by sponge bath, including the task of getting into or out of a tub or shower.

(ii) Continence: The ability of the insured to control bowel and bladder functions; or, in the event of incontinence, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(iii) Dressing: The ability of the insured to put on and take off all items of clothing, and necessary braces, fasteners, or artificial limbs.

(iv) Eating: The ability of the insured to feed himself or herself by getting food and drink from a receptacle (such as a plate, cup, or table) into the body including intravenously or by feeding tube.

(v) Toileting: The ability of the insured to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene.

(vi) Transferring: The ability of the insured to move in and out of a chair, bed, or wheelchair.

(b) For purposes of this section, the determination of a deficiency shall not be more restrictive than:

(i) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(ii) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

(c) Upon prior approval of the commissioner in writing, an insurer may use standards or definitions for activities of daily living in addition to the standards set forth in (a) of this subsection; however, in no case may an insurer require a deficiency in more than three activities of daily living as a barrier to benefits. Any additional activities of daily living approved by the commissioner, shall be used in addition to those set forth in (a) of this subsection, and not in lieu thereof. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers. No contract or certificate may combine more than one activity of daily living to create a compound impairment requirement.

(d) Each long-term care insurance contract or certificate shall include a clear description of the process for appealing and resolving benefit determinations.

(4) If an insurer proposes standards other than those described in this section, the insurer shall describe to the satisfaction of the commissioner how the proposed assessment will reasonably be expected to produce reliable, valid, and clinically appropriate results and shall demonstrate that the alternate assessment method is not less beneficial to the insured than the standards described in this section.

(5) For purposes of this section the following definitions apply:

(a) "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(b) "Hands-on assistance" means any amount of physical assistance (whether minimal, moderate, or maximal) without which the insured would not be able to perform the activity.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050, 95-19-028 (Order R 95-5), § 284-54-040, filed 9/11/95, effective 10/12/95.]

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;

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

(9) Rest cures and routine physical examinations;

(10) Chemical dependency;

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

(12) Benefits provided under medicare or other governmental programs (except medicaid);

(13) Experimental treatments, supplies, or services;

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

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

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

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

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

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

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

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

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(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 284-54-180 Reduction of coverage. Effective January 1, 1996, every person purchasing a long-term care insurance contract in this state shall have the right to reduce the benefits of a long-term care contract without providing evidence of insurability. Such a reduction may include, for example, changes which result in a contract with a longer elimination period, a lower daily benefit, or a shorter benefit period: Provided, however, That an insurer shall not reduce benefits to a level below the minimum level which has been approved by the commissioner on the date the reduction of coverage is requested.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-180, filed 9/11/95, effective 10/12/95.]

WAC 284-54-190 Nonduplication with state or national health care benefits. In the event that a state or federal program is enacted which substantially duplicates all or part of the coverage of an in-force long-term care insurance contract or certificate, current benefits or features which are

duplicated by a state or national program shall be revised or eliminated promptly and in an orderly manner, subject to prior approval by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-190, filed 9/11/95, effective 10/12/95.]

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 284-54-253 Unintentional lapse. The purpose of this section is to protect insureds from unintentional lapse by establishing standards for notification of a designee to receive notice of lapse for nonpayment of premiums at least thirty days prior to the termination of coverage and to provide for a limited right to reinstatement of coverage unintentionally lapsed by a person with a cognitive impairment or loss of functional capacity. These are minimum standards and do not prevent an insurer from including benefits more favorable to the insured. This section applies to every insurer providing long-term care coverage to a resident of this state, which coverage is issued for delivery or renewed on or after January 1, 1996.

(1) Every insurer shall permit an insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, if the premium is not paid on or before its due date. The designation shall include the designee's full name and home address.

(a) The notice shall provide that the contract or certificate will not lapse until at least thirty days after the notice is mailed to the insured's designee.

(b) Where a policyholder or certificateholder pays premium through a payroll or pension deduction plan, the insurer shall permit the insured to designate a person to receive notice of lapse or termination for nonpayment of premium within sixty days after the insured is no longer on such a premium payment plan. The application or enrollment form for contracts or certificates where premium will be paid through a payroll or pension deduction plan shall clearly indicate the payment plan selected by the applicant.

(c) The insurer shall offer each insured in writing an opportunity to change the designee, or update the information concerning the designee, no less frequently than once in every twenty-four months.

(2) Every insurer shall provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity and reinstatement is requested within the five months after the policy lapsed or terminated due to nonpayment of premium.

(a) The standard of proof of cognitive impairment or loss of functional capacity shall be no more restrictive than the benefit eligibility criteria for cognitive impairment or loss of functional capacity contained in the contract or certificate.

(b) Current good health of the insured shall not be required for reinstatement if the request otherwise meets the requirements of this section.

(3) An insurer shall permit an insured to waive his or her right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

(a) The waiver shall be in writing, and shall be dated and signed by the applicant or insured.

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(b) No less frequently than once in every twenty-four months, the insured shall be permitted to revoke this waiver and to name a designee.

(4) Designation by the insured to receive notice of lapse or termination for nonpayment of premium does not constitute acceptance of any liability on the part of the designee for services provided to the insured or applicant.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-253, filed 9/11/95, effective 10/12/95.]

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 policyholder 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)(a) Insurers shall include the following information in or with the disclosure form:

(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 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-270, filed 9/11/95, effective 10/12/95. Statutory Authority: RCW 48.02.060, 48.84.030 and 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 the form 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 shall 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 284-66-120.

(9) The required disclosure form shall 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 approval or acceptance prior to use in this state.

(11) Upon request of an applicant or insured, insurers shall make available a disclosure form in a format which meets the requirements of the Americans With Disabilities Act and which has been approved in advance by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-300, filed 9/11/95, effective 10/12/95. 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. No later than January 1, 1996, the disclosure form shall be substantially as follows:

(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.

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

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

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.

LTC DISCLOSURE FORM

1. INSTITUTIONAL CARE

What levels of care are covered by the policy?

Does the policy provide benefits for these levels of care?

Skilled Nursing Care?

Intermediate Nursing Care?

Custodial/Personal Care?

(By state law, all long-term care policies in Washington State must cover all three of the above levels of care.)

YES

NO

Form with lines for YES and NO responses for the three care levels.

Where can care be received and be covered under the policy?

Does the policy pay for care in any licensed facility?

If no, define the restrictions on where care can be obtained:

Is the alternative plan of care benefit available with institutional part of policy?

Does the alternative plan of care benefit include home care?

Does the alternative plan of care benefit include structural home improvements?

Form with lines for YES and NO responses, and space for 'If yes, see section 2'.

2. HOME/COMMUNITY BASED CARE

What types of care are covered by the policy?

Does the policy provide home care benefit for:

Check all that apply

- Adult day care
Adult day health care
Chore services
Home health aides
Homemaker services
Hospice
Hygiene/personal care
Laboratory services
Meals/nutrition services
Medical equipment/supplies
Prescription drugs
Physician/nursing services
Respite care
Social workers
Therapies (List)
Transportation
Other: _____

Form with lines for YES and NO responses for each care type.

Are these separate or post-confinement benefits?

Separate Post - Confinement

Where can home/community-based care be received?

Check all that apply

- Adult day care centers
Alternative care facilities
Assisted living facilities
Boarding homes
Community centers
Congregate care facilities
Multiple family residences
Single family residences
Other: _____

Form with lines for YES and NO responses for each location type.

Does the alternative plan of care benefit include home care?

Does the alternative plan of care benefit include structural improvements?

Must the alternative plan of care be pre-certified?

If yes, by whom? _____

Form with lines for YES and NO responses.

3. BOTH INSTITUTIONAL AND COMMUNITY-BASED CARE

What is the maximum daily benefit amount for:

- Institutional/nursing home care?
Home/Community Based Care?
Are there limits on the number of days (or visits) per year for which benefits will be paid for:
Institutional/nursing home care?

YES/NO/COMMENTS

Form with lines for YES/NO/COMMENTS.

Home/Community based care?
 What are the dollar limits the policy will pay during the policyholder's lifetime for:
 Institutional/Nursing home care?
 Home/Community based care?
 Total lifetime limit?

What basic features and benefits does the policy offer?

Is the policy guaranteed renewable?
 Can you purchase additional increments of coverage? If yes:
 When can additional coverage be purchased?
 How much can be purchased?
 When is additional coverage no longer available for purchase?

Does the policy have inflation protection?

If yes, what is the % amount of the increase?
 Is the rate of increase simple or compound?
 When do increases stop?

If policy includes inflation coverage, what is the daily benefit for:

Institutional/nursing home care.
 5 years from policy effective date?
 10 years from policy effective date?
 Home/Community based care.
 5 years from policy effective date?
 10 years from policy effective date?

After the limits have been reached for inflation adjustments, what is the maximum daily benefit for:

Institutional/nursing home care
 Home/community based care

After the limits have been reached for inflation adjustments, what is the maximum lifetime benefit for:

Institutional/nursing home care
 Home/community based care

Is there a waiver of premium provision for:

Institutional/nursing home care?
 Home/community based care?
 How many days of confinement in an institution are required before the waiver of premium benefit is available?
 How many days of confinement at home are required before the waiver of premium benefit is available?
 How many days of benefits must be paid before waiver is effective?

Does the policy have a nonforfeiture benefit?

If yes, how many years must policy be in effect before the insured benefits from nonforfeiture values?
 What would the benefit value be in terms of dollars after 20 years?
 What does the nonforfeiture benefit promise? (give an appropriate example showing dollars and time limits)

Does the policy have a death benefit?

If yes, specify value (in dollars or %)
 What conditions or limitations apply, if any?

Does the policy have a restoration of benefits provision?

If yes, give amount of benefit and minimum required # of days between benefits.
 If disability recurs, is there a new elimination or waiting period before benefits begin again?
 If yes, after how long?
 How long is the waiting period for preexisting conditions?
 How is the preexisting condition defined?

When do benefits begin?

How long is the elimination or waiting period before benefits begin for:
 Institutional/nursing home care?
 Home/community based care?

What gatekeepers are required before benefits start?

Doctor certification
 Case management
 If yes, by whom?
 Medical necessity
 Plan of treatment
 If yes, by whom?
 Inability to perform activities of daily living (ADLs)
 If yes, how many ADLs must fail before benefits begin?

If the policy uses an ADL gatekeeper(s), define "inability to perform ADL."

Is there a separate benefit qualification requirement if there is a cognitive impairment?
 Who determines a qualifying event?
 Define any separate benefit qualification requirement if there is a cognitive impairment:

What does the policy cost?

How often can the premium increase?

By how much annually can the premium increase?
 Is there a discount if both spouses buy policies?
 If so, how much?

Do you lose the discount if one spouse dies? _____

4. ADDITIONAL POLICY INFORMATION

Use this space to outline additional benefits, further explanations or clarifications

5. POLICY DEFINITIONS

(Include definitions of policy provisions)

WHAT DOES THE POLICY COST?

COMPANY NAME.	POLICY OPTION 1	POLICY OPTION 2	POLICY OPTION 3	POLICY OPTION 4
ELIMINATION (DEDUCTIBLE) PERIOD BENEFIT PERIOD \$ BENEFIT FOR DAY \$ MAXIMUM BENEFIT	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
Institutional/Nursing Home Home Health/Community Based PREMIUM SUBTOTAL \$	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
OPTIONAL BENEFITS Inflation Non Forfeiture Spousal Discount Death Benefit Other _____ Other _____ Other _____ PREMIUM TOTAL \$	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
BENEFIT "TRIGGERS" (QUALIFICATION REQUIREMENTS) List _____ List _____ List _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

[Statutory Authority: RCW 48.02.060, 48.84.030 and 48.84.050. 95-19-028 (Order R 95-5), § 284-54-350, filed 9/11/95, effective 10/12/95. 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.]

[Title 284 WAC—p. 300]

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 non-random 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:

(2009 Ed.)

(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.]

(2009 Ed.)

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 284-54-750 Standards for education of licensees soliciting long-term care contracts. (1) Every issuer shall annually certify to the commissioner that each resident

and nonresident licensee involved in the transaction of long-term care insurance has completed an approved LTC special education course every two years in accordance with WAC 284-17-258. Applications may only be accepted if the lic-

ensee involved in the transaction meets all of the requirements of WAC 284-17-258.

(2) Beginning with the calendar year 1998, issuers shall file a copy of the following certification report with the commissioner on or before March 31 of each year:

Annual Filing of Compliance with the Long-Term Care and Long-Term Care Partnership Education Requirements of WAC 284-17-258

To be filed with the commissioner on or before March 31 of each year

For the period of January 1 to December 31 of _____ (Year)

Company Name _____

Address _____

Insurance Policies Offered:

Long-Term Care _____ Long-Term Care Partnership _____ Both _____

I hereby certify that all appointed agents involved in the transaction of each long-term care or long-term care partnership policy we issue in Washington have fulfilled the requirements of WAC 284-17-258. I certify that to the best of my knowledge, we did not accept or process any applications that involved the participation of a licensee who was not in compliance with WAC 284-17-258.

Signature of Officer:

Date:

Name and Title of Officer:

Prepared by:

Phone Number:

Phone Number:

Return Certification Form to: Education Manager Office of the Insurance Commissioner P.O. Box 40257 Olympia, WA 98504-0257 Fax 360-586-2019

[Statutory Authority: RCW 48.02.060, 48.17.150, and 48.85.030. 05-09-022 (Matter No. R 2005-01), § 284-54-750, filed 4/12/05, effective 5/13/05; 97-19-007, § 284-54-750, filed 9/4/97, effective 10/5/97.]

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**

WAC

- 284-55-010 Limited purpose of this chapter.
- 284-55-020 Applicability and scope.
- 284-55-030 Definitions.
- 284-55-035 Policy definitions and terms.
- 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.
- 284-55-080 Form for "replacement notice."
- 284-55-090 Form for "replacement notice" by direct response insurer.
- 284-55-095 Prohibited compensation for replacement with the same insurer.
- 284-55-115 Standards for loss ratios.
- 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.

(2009 Ed.)

- 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.

**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 89-7), § 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 pre-

scribing 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.]

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, dis-

tortion, 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 stan-

dards. 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:)

.....

SERVICE	THIS POLICY PAYS	YOU 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 CHANGED 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			

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but \$270 a day for 91st - 150th days (if individual chooses to use 60 nonrenewable lifetime reserve days) per benefit period			
Skilled Nursing Facility Care	100% of costs for for 1st 20 days (after 3-day prior hospital confinement) All but \$67.50 a day for 21st - 100th days Nothing beyond 100 days	80% of medicare reasonable costs for first 8 days per calendar year without prior hospitalization requirement 100% of costs thereafter up to 150 days/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year
Blood	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> .	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)

Part A blood deductible reduced to the extent paid under Part B.

Part B
MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Parts A & B:				
Home Health Services	Intermittent skilled nursing 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)	
PART B				
Medical Expense: Services of a Physician/ Outpatient 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)	

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
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, 1991)		
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)
Out-of-Pocket Maximum				\$1,370 consisting of Part B \$75 deductible, Part B blood deductible and 20% co-insurance (same 1990 & 1991, except \$1,370 will be adjusted annually by Sec. Health & Human Services)
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)
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)		
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)

(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:

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.....
(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

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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.)

<u>MEDICARE BENEFITS</u>		<u>YOUR MEDICARE SUPPLEMENT COVERAGE</u>	
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

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	

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.

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).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-165, filed 11/1/88.]

WAC 284-55-180 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

Form No.	No. of Contracts in Force	Policy Duration	Incurred Losses	Earned Premiums	Loss Ratio	Unearned Premium Reserve	Policy Reserves	Claim Reserves
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Washington Experience

Form No.	No. of Contracts in Force	Policy Duration	Incurred Losses	Earned Premiums	Loss Ratio	Unearned Premium Reserve	Policy Reserves	Claim Reserves
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MEDICARE SUPPLEMENT LOSS RATIO EXPERIENCE
(SUMMARIZED BY POLICY YEAR)

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, and 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

LIFE AND DISABILITY FORM AND RATE FILINGS

WAC

284-58-005	Definitions that apply to this chapter.
284-58-010	Purpose of this chapter.
284-58-020	Scope of this chapter.
284-58-023	Certification process does not apply to life, disability or credit insurance forms.
284-58-025	Filing instructions that are incorporated into this chapter.
284-58-030	General form and rate filing rules.
284-58-033	Specific rate filing rules.
284-58-037	The commissioner may reject filings.
284-58-043	Filing authorization rules.
284-58-047	Rules for responding to an objection letter.
284-58-053	Rules for revised or replaced insurance policy forms.
284-58-057	Effective date rules.
284-58-061	Reference copies of amendatory endorsements.
284-58-066	Rules that apply to insurance forms translated from English to another language.

284-58-110	Blanket disability insurance forms, certification not permitted. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-110, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-120	Blanket disability insurance forms which may be filed by certification. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-120, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-130	Individual life insurance and annuity forms, certification not permitted. [Statutory Authority: RCW 48.02.-060. 82-23-009 (Order R 82-5), § 284-58-130, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-140	Individual life insurance and annuity forms which may be filed by certification. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-140, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-150	Group life insurance and annuity contract forms, certification not permitted. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-150, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-160	Group life insurance and annuity forms which may be filed by certification. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-160, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-170	Credit insurance forms, certification not permitted. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-170, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-180	Fraternal benefit society forms. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-180, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-190	Certification form to be used for disability insurance form filings. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-190, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-200	Form to be used for certification of disability insurance form or rate filings. [Statutory Authority: RCW 48.02.-060. 82-23-009 (Order R 82-5), § 284-58-200, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-210	Certification form to be used for life insurance and annuity form filings. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-210, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-220	Form to be used for certification of life insurance or annuity form filings. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-220,

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-58-040	Life and disability filing report documents. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-040, filed 11/5/82.] Repealed by 98-09-041 (Matter R 98-01), filed 4/14/98, effective 5/15/98. Statutory Authority: RCW 48.02.060, 48.17.150, 48.44.-040, 48.46.200 and 48.44.050.
284-58-050	Document to be used in filing life and disability forms. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-050, filed 11/5/82.] Repealed by 98-09-041 (Matter R 98-01), filed 4/14/98, effective 5/15/98. Statutory Authority: RCW 48.02.060, 48.17.-150, 48.44.040, 48.46.200 and 48.44.050.
284-58-060	Document to be used in filing disability rates. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-060, filed 11/5/82.] Repealed by 98-09-041 (Matter R 98-01), filed 4/14/98, effective 5/15/98. Statutory Authority: RCW 48.02.060, 48.17.150, 48.44.-040, 48.46.200 and 48.44.050.
284-58-070	General designation of life and disability forms which may not be filed by certification. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-070, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-080	Individual disability insurance forms, certification not permitted. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-080, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-090	Group disability insurance forms, certification not permitted. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-090, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
284-58-100	Group disability insurance forms which may be filed by certification. [Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-100, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.

- 284-58-250 filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
General contents of a form filing for property and casualty insurance and kinds of insurance other than life and disability. [Statutory Authority: RCW 48.02.060, 98-13-094 (Matter No. R 98-11), § 284-58-250, filed 6/16/98, effective 7/17/98. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21.045(2), 48.29.-140, 48.43.055, 48.44.023(2), 48.44.040, 48.44.070, 48.46.030, 48.46.060, 48.46.066(2), 48.46.243, 48.96.-025, 48.102.020, 96-11-004 (Matter No. R 96-1), § 284-58-250, filed 5/2/96, effective 6/2/96. Statutory Authority: RCW 48.02.060, 82-23-009 (Order R 82-5), § 284-58-250, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.150.
- 284-58-260 Designation of forms for insurances which may not be filed by certification. [Statutory Authority: RCW 48.02.060, 98-13-094 (Matter No. R 98-11), § 284-58-260, filed 6/16/98, effective 7/17/98; 82-23-009 (Order R 82-5), § 284-58-260, filed 11/5/82.] Repealed by 08-21-091 (Matter No. 2007-11), filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.110.-150.
- 284-58-270 Certification form to be used for property and casualty insurance. [Statutory Authority: RCW 48.02.060, 82-23-009 (Order R 82-5), § 284-58-270, filed 11/5/82.] Repealed by 98-13-094 (Matter No. R 98-11), filed 6/16/98, effective 7/17/98. Statutory Authority: RCW 48.02.060.
- 284-58-280 Form to be used for certification of property or casualty insurance form filings. [Statutory Authority: RCW 48.02.060, 82-23-009 (Order R 82-5), § 284-58-280, filed 11/5/82.] Repealed by 98-13-094 (Matter No. R 98-11), filed 6/16/98, effective 7/17/98. Statutory Authority: RCW 48.02.060.

WAC 284-58-005 Definitions that apply to this chapter. The definitions in this section apply throughout this chapter.

- (1) "Complete filing" means a package of information containing insurance forms, supporting information, documents and exhibits submitted to the commissioner electronically using the System for Electronic Rate and Form Filing (SERFF).
- (2) "Credit insurance" means the types of insurance defined in RCW 48.34.030 (1) and (2).
- (3) "Date filed" means the date a complete filing has been received and accepted by the commissioner.
- (4) "Disability insurance" means the same as in RCW 48.11.030.
- (5) "Filer" means a person, organization or other entity that files insurance forms or rates with the commissioner for an insurer.
- (6) "Insurance" means the same as in RCW 48.01.040.
- (7) "Insurer" means an insurer defined in RCW 48.01.-050 that has been issued a certificate of authority by the commissioner under chapter 48.05 RCW.
- (8) "Life insurance" means the same as in RCW 48.11.-020.
- (9) "NAIC" means the National Association of Insurance Commissioners.
- (10) "Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:
 - (a) Requests clarification, documentation or other information;
 - (b) Explains errors or omissions in the filing; or
 - (c) Disapproves a form under RCW 48.18.110.

(11) "Rate" or "rates" means all classification manuals, rate or rule manuals, rating plans, rating schedules, minimum rates, class rates, and rating rules that insurers must file under RCW 48.19.010(2) and 48.34.100.

(12) "SERFF" means the System for Electronic Rate and Form Filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

(13) "Type of insurance" means a specific type of insurance listed in the *Uniform Life, Accident and Health, Annuity and Credit Coding Matrix* published by the NAIC and available at www.naic.org.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-58-005, filed 10/15/08, effective 2/1/09.]

WAC 284-58-010 Purpose of this chapter. This chapter contains the Washington state life, disability and credit insurance form and rate filing requirements.

The purpose of this chapter is to adopt processes and procedures for insurers and filers to use when submitting life, disability and credit insurance products with the commissioner. Rules in this chapter:

- (1) Establish the necessary contents of a form filing;
- (2) Establish the filing requirements for credit and disability insurance classification plan and rate and rule manuals; and
- (3) Effective February 1, 2009, designate SERFF as the method by which filers must submit life, credit and disability filings to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-58-010, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 98-13-094 (Matter No. R 98-11), § 284-58-010, filed 6/16/98, effective 7/17/98; 82-23-009 (Order R 82-5), § 284-58-010, filed 11/5/82.]

WAC 284-58-020 Scope of this chapter. (1) This chapter applies to all life and disability insurers that must file forms and rates under RCW 48.18.100, 48.19.010(2) and 48.34.100.

(2) Under RCW 48.18.100, the commissioner is required to act within thirty days to approve or disapprove a form. The commissioner may extend the review period to forty-five days under RCW 48.18.100(3). If the commissioner does not act within the review period, the form is deemed approved and the insurer may use the form. The commissioner may subsequently withdraw approval of a form for cause.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-58-020, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 98-13-094 (Matter No. R 98-11), § 284-58-020, filed 6/16/98, effective 7/17/98; 82-23-009 (Order R 82-5), § 284-58-020, filed 11/5/82.]

WAC 284-58-023 Certification process does not apply to life, disability or credit insurance forms. Insurers may not use the certification process described in RCW 48.18.100(2) to file life, disability or credit insurance forms. Insurers must file these forms under RCW 48.18.100(1) or 48.34.100.

[Statutory Authority: RCW 48.02.060, 48.110.150, 08-21-091 (Matter No. 2007-11), § 284-58-023, filed 10/15/08, effective 2/1/09.]

WAC 284-58-025 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* posted on the SERFF web site (www.serff.com); and

(2) The *Washington State SERFF Life and Disability Rate and Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-025, filed 10/15/08, effective 2/1/09.]

WAC 284-58-030 General form and rate filing rules.

(1) Each credit, life or disability insurance form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must be attached to the form schedule.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* posted on the SERFF web site (www.serff.com) and the *Washington State Life and Disability Form Filing General Instructions* posted on the commissioner's web site (www.insurance.wa.gov).

(4) Filers must submit separate filings for each type of insurance. This section does not apply to:

(a) Credit insurance filings made under RCW 48.34.040; or

(b) Group insurance where different types of insurance are incorporated into a single certificate.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-030, filed 10/15/08, effective 2/1/09. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200, 48.18.100, 48.19.040, 48.19.050, 48.19.070, 48.20.012, 48.21.045(2), 48.29.140, 48.43.055, 48.44.023(2), 48.44.040, 48.44.070, 48.46.030, 48.46.060, 48.46.066(2), 48.46.243, 48.96.025, 48.102.020. 96-11-004 (Matter No. R 96-1), § 284-58-030, filed 5/2/96, effective 6/2/96. Statutory Authority: RCW 48.02.060. 82-23-009 (Order R 82-5), § 284-58-030, filed 11/5/82.]

WAC 284-58-033 Specific rate filing rules. (1) If a rate filing is required under RCW 48.19.010(2) or 48.34.100, it must be submitted:

(a) Separate from any corresponding form filing; and
(b) Concurrently with the corresponding form filing if new forms are being introduced.

(2) Each rate filing must include, if appropriate:

(a) Rates, manuals of classification, manuals of rules and rates and modifications thereof;

(b) Actuarial memorandum of nonforfeiture values;

(c) Actuarial demonstration of anticipated loss ratio; and

(d) Any additional data or information requested by the commissioner.

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[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-033, filed 10/15/08, effective 2/1/09.]

WAC 284-58-037 The commissioner may reject filings. (1) The commissioner may reject and close any filing that does not comply with WAC 284-58-030 or 284-58-033. If the commissioner rejects a filing, the insurer has not filed forms or rates with the commissioner.

(2) If the commissioner rejects a filing and the filer resubmits it as a new filing, the date filed will be the date the commissioner receives and accepts the new filing.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-037, filed 10/15/08, effective 2/1/09.]

WAC 284-58-043 Filing authorization rules. An insurer may authorize a third-party filer to file forms or rates on its behalf. For the purposes of this section, a "third-party filer" means a person or entity in the business of providing insurance regulatory compliance services.

(1) If an insurer delegates filing authority to a third-party filer, each filing must include a letter as supporting documentation signed by an officer of the insurer authorizing the third-party filer to make filings on behalf of the insurer.

(2) The insurer may not delegate responsibility for the content of a filing to a third-party filer. The commissioner considers errors and omissions made by the third-party filer to be errors and omissions of the insurer.

(3) If a third-party filer has a pattern of making filings that do not comply with this chapter, the commissioner may reject a delegation of filing authority from the insurer.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-043, filed 10/15/08, effective 2/1/09.]

WAC 284-58-047 Rules for responding to an objection letter. An objection letter may ask the filer to revise a noncompliant form or rate filing or provide clarification or additional information. The objection letter will state the reason(s) for disapproval, including relevant case law, statutes and rules. Filers must:

(1) Provide a complete response to an objection letter. A complete response must include:

(a) A separate response to each objection, and if appropriate;

(b) A description of changes proposed to noncompliant forms, and a replacement form attached to the form schedule; or

(c) Revised exhibits and supporting documentation.

(2) Respond to the commissioner in a timely manner.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-047, filed 10/15/08, effective 2/1/09.]

WAC 284-58-053 Rules for revised or replaced insurance policy forms. If an insurer files a revised or replaced form, the filer must provide the supporting documentation described below:

(1) If a form is revised due to an objection(s) from the commissioner, the filer must provide a detailed explanation of all material changes to the disapproved form.

(2) If a previously approved form is replaced with a new version, the filer must submit an exhibit that marks and iden-

tifies each change or revision to the replaced form using one of these methods:

- (a) A draft form that strikes through deletions and underlines additions or changes in the form;
- (b) A draft form that includes comments in the margins explaining the changes in the forms; or
- (c) A side-by-side comparison of current and proposed policy language.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-053, filed 10/15/08, effective 2/1/09.]

WAC 284-58-057 Effective date rules. (1) Filers must include a common approval date for all forms or rates submitted in a filing.

(2) Filers may submit a request to change the approval date of a filing as a note to reviewer.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-057, filed 10/15/08, effective 2/1/09.]

WAC 284-58-061 Reference copies of amendatory endorsements. If an insurer will use a previously approved Washington amendatory endorsement with a new form, the filer must:

- (1) Provide a copy of the amendatory endorsement attached as supporting documentation; or
- (2) Include the SERFF tracking number under which the endorsement was filed and approved in the filing description; and
- (3) Explain how the insurer will use the amendatory endorsement with the new form.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-061, filed 10/15/08, effective 2/1/09.]

WAC 284-58-066 Rules that apply to insurance forms translated from English to another language. Insurers may issue insurance policy forms written in languages other than English.

(1) If an insurer translates an insurance policy form from English to another language, the insurer must:

- (a) File the translated version of the form.
- (b) Include written disclosure statements on the translated policy form that the insurer is issuing the translated form on an informational basis and the English version is controlling for the purposes of application and interpretation. The disclosure statements must be in English and the language of the translated form and printed in bold face type of at least twelve-point font.

(c) Submit a certification with the filing by an officer employed by the insurer that the insurer will issue the English version of the policy form with the translated policy form.

- (2) When filing a translated policy form, the filer must:
 - (a) Identify the approved English version of the policy form by providing, as applicable, the:
 - (i) SERFF filing number;
 - (ii) Form number, edition date or edition identifier; and
 - (iii) Effective date of the filing.
 - (b) Submit certification by a professional translator certified by the American Translators Association or a comparable organization that the:

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- (i) Translator has translated the English version of the form; and
- (ii) Translation is accurate.
- (3) The commissioner will file but not review or approve translated insurance policy forms.

[Statutory Authority: RCW 48.02.060, 48.110.150. 08-21-091 (Matter No. 2007-11), § 284-58-066, filed 10/15/08, effective 2/1/09.]

Chapter 284-60 WAC

DISABILITY INSURANCE LOSS RATIOS

WAC

284-60-010	Scope.
284-60-020	Purpose.
284-60-030	Definitions.
284-60-040	Grouping of policy forms for purposes of rate making and requests for rate increase.
284-60-050	Loss ratio requirements for individual disability insurance forms.
284-60-060	Loss ratio requirement for group and blanket disability insurance policy forms and manual rates.
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, pur-

suant 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.

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[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

(2009 Ed.)

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:

(2009 Ed.)

(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 calcu-

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lations. 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 sched-

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ule 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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- 284-66-040 Policy definitions and terms.
- 284-66-050 Policy provisions.
- 284-66-060 Minimum benefit standards.
- 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992.
- 284-66-066 Standard medicare supplement benefit plans.
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- 284-66-170 Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates.
- 284-66-200 Standards for loss ratios.
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- 284-66-210 Policy reserves required.
- 284-66-220 Medicare supplement refund calculation form required.
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- 284-66-240 Filing requirements and premium adjustments.
- 284-66-243 Filing and approval of policies and certificates and premium rates.
- 284-66-247 Interim rate and form filing requirements for standardized plans H, I and J and prestandardized plans that include outpatient prescription drug benefits.
- 284-66-250 Filing requirements for out-of-state group policies.
- 284-66-260 Riders and endorsements.
- 284-66-270 Standards for claims payment: Compliance with Omnibus Budget Reconciliation Act of 1987.
- 284-66-300 Requirements for advertising.
- 284-66-310 Attained age rating prohibited.
- 284-66-320 Reporting of multiple policies.
- 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.
- 284-66-400 Chapter not exclusive.

**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.
- 284-66-077 Open enrollment. [Statutory Authority: RCW 48.02.-060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-077, filed 4/11/96, effective 5/12/96. 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.] Repealed by 05-17-019 (Matter No. R 2004-08), filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060 and 48.66.165.
- 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 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.
- 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 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 that may duplicate medicare benefits as the federal medicare program changes; to facilitate public understanding and comparison of policies and to eliminate provisions contained in policies that 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-010, filed 8/4/05, effective 9/4/05. 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 applies to every group and individual policy of disability insurance and to every subscriber contract of an issuer (other than a policy issued under a contract provided for in section 1876 of the Social Security Act [42 U.S.C. section 1395 et seq.] or an issued policy under a demonstration project specified in 42 U.S.C. section 1395ss (g)(1)), that relates its benefits to medicare, or 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 before January 1, 1989, that are renewable solely at the option of the insured by the timely payment of premium are 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 these policies, chapter 284-55 WAC applies.

(b) Medicare supplement insurance policies delivered between January 1, 1989, and December 31, 1989, that are renewable solely at the option of the insured by the timely payment of premium are 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-020, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-020, filed 4/11/96, effective 5/12/96. 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 relating to disability insurance. For purposes of this chapter, disability insurance includes policies or contracts offered by any issuer.
- (7) "Health care expense costs," for purposes of WAC 284-66-200(4), means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services that are analogous to incurred losses of insurers.
- (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 the policy is deemed part of the premium. "Earned premium" means the "premium" applicable to an accounting period whether received before, during or after that period.
- (11) "Replacement" means any transaction where 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 the transaction, existing medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

(12) "Secretary" means the Secretary of the United States Department of Health and Human Services.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-030, filed 8/4/05, effective 9/4/05. 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 as a medicare supplement insurance policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

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

(a) The definition may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that 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) The definition may provide that injuries do not include those 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) "Benefit period" or "medicare benefit period" may not be defined more restrictively than as defined in the medicare program.

(3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" may not be defined more restrictively than as defined in the medicare program.

(4) "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.

(5) "Medicare" must be defined in the policy and certificate as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended."

(6) "Medicare eligible expenses" means expenses of the kinds covered by medicare Parts A and B, to the extent recognized as reasonable and medically necessary by medicare.

(7) "Physician" may not be defined more restrictively than as defined in the medicare program.

(8) "Sickness" may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person that 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-040, filed 8/4/05, effective 9/4/05. 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 it meets or exceeds the requirements imposed by chapter 48.66 RCW.

(2) A medicare supplement policy or certificate in force in this state may not contain benefits that 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 the 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 may not be used to describe an insurance policy unless the policy is issued in compliance with chapter 48.66 RCW and this chapter.

(5) Subject to WAC 284-66-063 (1)(c), a medicare supplement policy with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(6) A medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005.

(7) After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare Part D enrollment, accounting for any claims paid, if applicable.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-050, filed 8/4/05, effective 9/4/05. 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), § 284-66-060, filed 3/20/90, effective 4/20/90.]

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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 that were modified to meet the minimum benefit standards of this section under the medicare Catastrophic Coverage Act. Minimum standards for "standardized" policies and certificates are provided in WAC 284-66-063.

(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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-060, filed 8/4/05, effective 9/4/05. 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 after June 30, 1992. 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.

[Title 284 WAC—p. 325]

(a) A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three 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 three months before the effective date of coverage.

(b) A medicare supplement policy or certificate may 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.

(c) Each medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may 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 must offer certificateholders an individual medicare supplement policy that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet 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 must 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 issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may 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 must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that 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. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(e) If a medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed requirements of this section.

(f)(i) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate be suspended at the request of the policyholder or certifi-

cateholder for the period (not to exceed twenty-four months) that 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 the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate must be automatically reinstated effective as of the date of termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period.

(iii) Each medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstated (effective as of the date of loss of coverage within ninety days after the date of the loss).

(g) Reinstitution of the coverages;

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstatement of the policy for medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must 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 benefit plans A-J. Every issuer must 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 place of the basic "core" package.

(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 one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment

system (PPS) rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and 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;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment 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 must 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. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(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. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(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, that

would have been covered by medicare if provided in the United States and that 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" means 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 not covered by medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must 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 may 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 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" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility is not 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 that 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 may 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.

(4) Standardized medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise appli-

cable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(5) Standardized medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-063, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-063, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-063, filed 4/11/96, effective 5/12/96. 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 must 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 may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3), (4) or (5) 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" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible as defined in WAC 284-66-063 (3)(a).

(c) Standardized medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized medicare supplement plan "D" consists of only the following: The core benefit, as defined in 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 in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized medicare supplement benefit plan "G" consists of 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 in WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(i) Standardized medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(j) Standardized medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(k) Standardized medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in 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 in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(l) Standardized medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in 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 outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(6) Make-up of two medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063(4).

(b) Standardized medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063(5).

(7) 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. The 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. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-066, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-066, filed 8/4/05, effective 9/4/05. 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 applies 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, that 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 that 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 where 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, under 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 may 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 must file a proposed plan of operation with the commissioner in a format prescribed by

the commissioner. The plan of operation must 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) The 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 must reflect usual practice in the local area. Geographic availability must 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 the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare SELECT policy or certificate. This paragraph does 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 used.

(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 must file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner before implementing the changes. The changes will be considered approved by the commissioner after thirty days unless specifically disapproved.

(b) An updated list of network providers must be filed with the commissioner at least quarterly.

(7) A medicare SELECT policy or certificate may 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 the services through a network provider.

(8) A medicare SELECT policy or certificate must provide payment for full coverage under the policy for covered services that are not available through network providers.

(9) A medicare SELECT issuer must 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 must 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. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are used.

(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) Before the sale of a medicare SELECT policy or certificate, a medicare SELECT issuer must obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (9) of this section and that the applicant understands the restrictions of the medicare SELECT policy or certificate.

(11) A medicare SELECT issuer must have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures.

(a) The grievance procedure must 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 must provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(c) Grievances must be considered in a timely manner and must 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 must be taken promptly.

(e) All concerned parties must be notified about the results of a grievance.

(f) The issuer must report no later than each March 31st to the commissioner regarding its grievance procedure. The report must be in a format prescribed by the commissioner

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and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of the grievances.

(12) At the time of initial purchase, a medicare SELECT issuer must 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 must make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and does not contain a restricted network provision. The issuer must make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for three 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 at-home recovery services, or coverage for Part B excess charges.

(14) Medicare SELECT policies and certificates must provide for continuation of coverage in the event the Secretary of Health and Human Services determines that medicare SELECT policies and certificates issued under 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 must 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 that has comparable or lesser benefits and does not contain a restricted network provision. The issuer must make the 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 at-home recovery services, or coverage for Part B excess charges.

(15) A medicare SELECT issuer must 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-073, filed 8/4/05, effective 9/4/05. 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 284-66-080 Outline of coverage required. (1) Issuers must 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, must obtain an acknowledgement of receipt of the outline from the applicant.

(2) The "outline of coverage," must be completed in substantially the form set forth in WAC 284-66-092. The form of outline of coverage must be filed with the commissioner before being used 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 that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the 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 set forth in 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 must be in the language and format prescribed in WAC 284-66-092 in no less than twelve point type. All plans A-L must be shown on the cover page, and the plan(s) that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must 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 must substitute appropriate terminology.

[Statutory Authority: RCW 48.02.060 and 48.66.165, 05-17-019 (Matter No. R 2004-08), § 284-66-080, filed 8/4/05, effective 9/4/05. 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]

See Outlines of Coverage sections for details about ALL plans

These charts show the benefits included in each of the standard medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits for Plans A-J
Hospitalization: Part A coinsurance plus coverage for 365 additional days after medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E	F/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 Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility 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
				Preventive Care NOT covered by medicare					Preventive Care NOT covered by medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [\$] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[Company Name] does not offer the [high deductible plan F] [high deductible plan J] [high deductible plan F or J].

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by medicare		
	\$() Out-of-Pocket Annual Limit***	\$() Out-of-Pocket Annual Limit***

**Plan K and L provide for different cost-sharing for items and services A-J.

Once you reach the annual limit, the plan pays 100% of the medicare copayments, coinsurance, and deductibles for the rest of calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation. See Outlines of Coverage for details and exceptions.

(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 *Medicare and You* 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 as noted in WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$0 \$[] a day \$[] a day 100% of medicare eligible expenses \$0	\$[] (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 \$[]/day \$0	\$0 \$0 \$0	\$0 Up to \$[] 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 outpatient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN A
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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.

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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 \$[] 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	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN A
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of medicare approved amounts* Remainder of medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[] (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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	\$0	Up to \$[] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above medicare approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN B
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment			
First \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of medicare approved amounts	80%	20%	\$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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] 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 \$[]/day \$0	\$0 Up to \$[] 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

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] of medicare approved amounts* Remainder of medicare approved amounts Part B excess charges (Above medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% \$0	\$0 \$0 All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[] of medicare approved amounts*	\$0	\$[] (Part B deductible)	\$0
Remainder of medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN C
PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment			
First \$[] of medicare approved amounts*	\$0	\$[] (Part B deductible)	\$0
Remainder of medicare approved amounts	80%	20%	\$0

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 lifetime 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	All but \$[]	\$[] (Part A deductible)	\$0
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	\$0	100% of medicare eligible expenses	\$0**
- - - Beyond the additional 365 days	\$0	\$0	All costs

Medicare Supplement Insurance

284-66-092

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 \$[]/day \$0	\$0 Up to \$[] 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

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] 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	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D
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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
- - - Durable medical equipment First \$[] of medicare approved amounts*	\$0	\$0	\$[] (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 lifetime 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	All but \$[]	\$[] (Part A deductible)	\$0
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	\$0	100% of medicare eligible expenses	\$0**
- - - Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	Up to \$[] a day	\$0

Medicare Supplement Insurance

284-66-092

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
101st day and after	\$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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] 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	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN E
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[] (Part B deductible) \$0
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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	\$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
Remainder of charges	\$0		
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services 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

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with medicare*.

[PLAN F] [HIGH DEDUCTIBLE 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.
[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] 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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] 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	All approved amounts All but \$[]/day	\$0 Up to \$[] a day	\$0 \$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
101st day and after	\$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

***NOTICE: When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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.

[**This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] 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 \$[] of medicare approved amounts* Remainder of medicare approved amounts Part B excess charges (Above medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment			
First \$[] of medicare approved amounts*	\$0	\$[] (Part B deductible)	\$0
Remainder of medicare approved amounts	80%	20%	\$0

PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] 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 lifetime 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	All but \$[]	\$[] (Part A deductible)	\$0
91st day and after:	All but \$[] a day	\$[] a day	\$0
- - - While using 60 lifetime reserve days			
- - - Once lifetime reserve days are used:	All but \$[] a day	\$[] a day	\$0
- - - Additional 365 days	\$0	100% of medicare eligible expenses	\$0**
- - - Beyond the additional 365 days	\$0	\$0	All costs

Medicare Supplement Insurance

284-66-092

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	Up to \$[] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN G (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above medicare approved amounts)	\$0	80%	20%
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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 \$[] of medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 lifetime 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	All but \$[]	\$[] (Part A deductible)	\$0
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	\$0	100% of medicare eligible expenses	\$0**
- - - Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	Up to \$[] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

Medicare Supplement Insurance

284-66-092

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN H
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] 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%	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN H
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of medicare approved amounts* Remainder of medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[] (Part B deductible) \$0
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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 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges	\$0		

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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] 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 \$[]/day \$0	\$0 Up to \$[] 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

**NOTICE: When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN I
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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 \$[] 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%	\$[] (Part B deductible) \$0 \$0
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN I (continued)
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of medicare approved amounts* Remainder of medicare approved amounts 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 - - - Number of visits covered (must be received within 8 weeks of last medicare approved visit) - - - Calendar year maximum	100% \$0 80% \$0 \$0 \$0	\$0 \$0 20% Actual charges to \$40 a visit Up to the number of medicare approved visits, not to exceed 7 each week \$1,600	\$0 \$[] (Part B deductible) \$0 Balance
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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 lifetime maximum

[PLAN J] [HIGH DEDUCTIBLE 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.
[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] 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 \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] 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 \$[]/day \$0	\$0 Up to \$[] 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

***NOTICE: When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

Medicare Supplement Insurance

284-66-092

[PLAN J] [HIGH DEDUCTIBLE PLAN J]
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] 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.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the medicare deductibles for Part A and B, but does not include the plan's separate foreign travel emergency deductible]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] 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 \$[] of medicare approved amounts* Remainder of medicare approved amounts Part B excess charges (Above medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$[] of medicare approved amounts* Remainder of medicare approved amounts	\$0 \$0 80%	All costs \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN J] [HIGH DEDUCTIBLE PLAN J] (continued)
 PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of medicare approved amounts* Remainder of medicare approved amounts 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	100% \$0 80%	\$0 \$[] (Part B deductible) 20%	\$0 \$0 \$0
	\$0	Actual charges to \$40 a visit	Balance

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
--- Number of visits covered (must be received within 8 weeks of last medicare approved visit)		Up to the number of medicare approved visits, not to exceed 7 each week	
--- Calendar year maximum	\$0	\$1,600	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]
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 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by medicare First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

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	All but \$[]	\$[] (50% of Part A deductible)	\$[] (50% of Part A deductible)◆
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after: --- While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
--- Once lifetime reserve days are used: --- Additional 365 days	\$0	100% of medicare eligible expenses	\$0***
--- Beyond the additional 365 days	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 Up to \$[] a day ♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50% ♦ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments ♦

*****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN K
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed \$[] 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 \$[] of medicare approved amounts**** Preventative Benefits for medicare covered services Remainder of medicare approved amounts Part B excess charges (Above medicare approved amounts)	\$0 Generally 75% or more of medicare approved amounts Generally 80% \$0	\$0 Remainder of medicare approved amounts Generally 10% \$0	\$[] (Part B deductible)**** ♦ All costs above medicare approved amounts Generally 10% ♦ All costs (and they do not count toward annual out-of-pocket limit of \$[])*
BLOOD First 3 pints Next \$[] of medicare approved amounts**** Remainder of medicare approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$[] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for medicare-approved amounts to \$[4000] per year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

PLAN K (continued)
PARTS A & B

SERVICE	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 \$[] of medicare approved amounts*****	\$0	\$0	\$[] (Part B deductible)◆
Remainder of medicare approved amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

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	All but \$[]	\$[] (75% of Part A deductible)	\$[] (25% of Part A deductible)◆
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	\$0	100% of medicare eligible expenses	\$0***
- - - Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	Up to \$[] a day	Up to \$[] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments◆

****NOTICE:** When your medicare Part A hospital benefits are exhausted, the insurer stands in the place of medicare and will pay whatever amount medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN L
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***Once you have been billed \$[] 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 \$[] of medicare approved amounts**** Preventative Benefits for medicare covered services Remainder of medicare approved amounts Part B excess charges (Above medicare approved amounts)	\$0 Generally 75% or more of medicare approved amounts Generally 80% \$0	\$0 Remainder of medicare approved amounts Generally 15% \$0	\$[] (Part B deductible)****◆ All costs above medicare approved amounts Generally 5%◆ All costs (and they do not count toward annual out-of-pocket limit of \$[])*
BLOOD First 3 pints Next \$[] of medicare approved amounts**** Remainder of medicare approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ \$[] (Part B deductible)****◆ Generally 5%◆
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for medicare-approved amounts to \$[] per year. **However, this limit does NOT include charges from your provider that exceed medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by medicare for the item or service.**

PLAN L (continued)
 PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of medicare approved amounts**** Remainder of medicare approved amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$[] (Part B deductible)◆ 5%◆

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-092, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-092, filed 8/4/05, effective 9/4/05. 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 to persons eligible for medicare must provide to all such applicants the pamphlet "Guide to Health Insurance for People with Medicare," developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services, (CMS), or any reproduction or official revision of that pamphlet. The guide must 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.)

(2) Delivery of the guide must be made whether or not the policies or certificates are advertised, solicited, or issued as medicare supplement insurance policies or certificates.

(3) Except in the case of a direct response issuers, delivery of the guide must be made to the applicant at the time of application and acknowledgement of receipt of the guide must be obtained by the issuer. Direct response issuers must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(4) The guide must be reproduced in a form that is substantially identical in language, format, type size, type proportional spacing, bold character, and line spacing to the guide developed jointly by the National Association of Insurance Commissioners and CMS.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-110, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-110, filed 4/11/96, effective 5/12/96. 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 that are not medicare supplement policies. Any disability insurance policy or certificate (other than a medicare supplement policy or certificate or a policy issued according to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.)), disability income protection policy or other policy identified in RCW 48.66.020(1), whether issued on an individual or group basis, that purports to provide coverage to residents of this state eligible for medicare, must notify policyholders or certificate holders that the policy is not a medicare supplement insurance policy or certificate. The notice must be printed or attached to the first page of the outline of coverage or equivalent disclosure form, and must be delivered to the policyholder or certificate holder. If no outline of coverage is delivered, the notice must be attached to the first page of the policy or certificate delivered to insureds. The notice must be in no less than twelve point type and 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 "Guide to Health Insurance for People with Medicare" available from the company."

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-120, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-120, filed 4/11/96, effective 5/12/96. 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 must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another medicare supplement, medicare advantage, medicaid coverage, or another health 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 the questions and statements, may be used: If the coverage is sold without an agent, the supplementary application must be signed by the applicant.

[Statements]

(1) You do not need more than one medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are sixty-five or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for medicaid, the benefits and premiums under your medicare supplement policy can be suspended if requested 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 suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety days of losing medicaid eligibility. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement

ment policy can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medical assistance through the state medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

[Please mark Yes or No below with an "X"]

To the best of your knowledge.

(1)(a) Did you turn age 65 in the last 6 months?

Yes No

(b) Did you enroll in medicare Part B in the last 6 months?

Yes No

(c) If yes, what is the effective date?

(2) Are you covered for medical assistance through the state medicaid program?

[NOTE TO APPLICANT; If you are participating in a "Spend - Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes No

If yes,

(a) Will medicaid pay your premiums for this medicare supplement policy?

Yes No

(b) Do you receive any benefits from medicaid OTHER THAN payments toward your medicare Part B premium?

Yes No

(2009 Ed.)

(3)(a) If you had coverage from any medicare plan other than original medicare within the past 63 days (for example, a medicare advantage plan, or a medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START // END //

(b) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?

Yes No

(c) Was this your first time in this type of medicare plan?

Yes No

(d) Did you drop a medicare supplement policy to enroll in the medicare plan?

Yes No

(4)(a) Do you have another medicare supplement policy in force?

Yes No

(b) If so, with what company and what plan do you have [optional for Direct Mailers]?

(c) If so, do you intend to replace your current medicare supplement policy with this policy?

Yes No

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)

Yes No

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy?

START // END //

(If you are still covered under the other policy, leave "END" blank.)

(2) Agents must list any other medical or health insurance policies sold to the applicant.

(a) List policies sold that are still in force.

(b) List policies sold in the past five years that 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, must 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, must furnish the applicant, before issuing or delivering the medicare supplement insurance policy or certificate, a notice regarding replacement of medicare supplement insurance coverage. One copy of the notice, signed by the applicant and the agent (except where the coverage is sold without an agent), must be provided to the applicant and an additional signed copy must be kept by the issuer. A direct response issuer must 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, must be provided in substantially the form set forth in WAC 284-66-142 in no smaller than twelve point type, and must be filed with the commissioner before being used in this state.

(6) The notice required by subsection (4) of this section for a direct response insurer must be in substantially the form set forth in WAC 284-66-142 and must be filed with the commissioner before being used 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-130, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-130, filed 4/11/96, effective 5/12/96. 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 284-66-135 Disclosure statements to be used with policies that are not medicare supplement policies. Applications for the purchase of disability or other medical insurance policies or certificates, that are provided to persons eligible for medicare, must disclose the extent to which the policy duplicates medicare. The disclosure must be in the form provided by this section. The applicable disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

(1) Instructions for use of the disclosure statements for health insurance policies sold to medicare beneficiaries that duplicate medicare.

(a) Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a disability or other health insurance policy (the term "policy" or "policies"

includes certificates and contracts of all issuers) that duplicate medicare benefits unless it will pay benefits without regard to other disability or other health coverage and it includes the prescribed disclosure statement on or together with the application.

(b) All types of disability or other health insurance policies that duplicate medicare must include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary substantially from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(c) State and federal law prohibits insurers from selling a medicare supplement policy to a person that already has a medicare supplement policy except as a replacement.

(d) Property/casualty and life insurance policies are not considered disability or other health insurance.

(e) Disability income policies are not considered to provide benefits that duplicate medicare.

(f) Long-term care insurance policies that coordinate with medicare and other health insurance are not considered to provide benefits that duplicate medicare.

(g) The federal law does not preempt state laws that are more stringent than the federal requirements.

(h) The federal law does not preempt existing state form filing requirements.

(2) Disclosure statement to be used for policies that provide benefits for expenses incurred for accidental injury only.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insur-*

ance for People with Medicare, available from the insurance company.

- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(3) Disclosure statement to be used with policies that provide benefits for specified limited services.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any of the services covered by the policy are also covered by medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(4) Disclosure statement to be used with policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physical services
- hospice
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(5) Disclosure statement to be used with policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits because medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(6) Disclosure statement to be used with indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any expenses or service covered by the policy are also covered by medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice
- other approved items & services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(7) Disclosure statement to be used with policies that provide benefits for both expenses incurred and fixed indemnity basis.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a

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fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when:

- any expenses or service covered by the policy are also covered by medicare; or
- it pays the fixed dollar amount stated in the policy and medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice care
- other approved items & services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(8) Disclosure statement to be used with long-term care policies providing both nursing home and noninstitutional coverage.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.

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- √ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(9) Disclosure statement to be used with policies providing nursing home benefits only.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(10) Disclosure statement to be used with policies providing home care benefits only.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.

- This insurance does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

Neither medicare nor medicare supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

(11) Disclosure statement to be used with other health insurance policies not specifically identified in the previous statements.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your medicare deductibles or coinsurance and is not a substitute for medicare supplement insurance.

This insurance duplicates medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about medicare and medicare supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program [SHIP].

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-135, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-135, filed 4/11/96, effective 5/12/96.]

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 OR MEDICARE ADVANTAGE

[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 or medicare advantage 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. If, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision, you should terminate your present medicare supplement or medicare advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy. STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this medicare supplement policy will not duplicate your existing medicare supplement or, if applicable, medicare advantage coverage because you intend to terminate your existing medicare supplement coverage or leave your medicare advantage plan. 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.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a medicare advantage plan. Please explain reason for disenrollment. [optional only for direct mailers]
- Other. (please specify)

1. NOTE: If the issuer of the medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. If you have had your current medicare supplement policy less than three 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 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-142, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-142, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-142, filed 4/11/96, effective 5/12/96. 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 before the effective date of any medicare benefit changes, every issuer providing medicare supplement insurance coverage to a resident of this state must 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 must be filed with the commissioner before being used.

(1) The notice must 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 must 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 must be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice must not contain or be accompanied by any solicitation.

(5) Issuers must comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-160, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-160, filed 8/4/05, effective 9/4/05. 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 must 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 the time was spent under the original policy.

(2) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate that has been in effect for at least three months, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-170, filed 8/4/05, effective 9/4/05. 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 before July 1, 1992, unless the policies are approved under the standards of WAC 284-66-063 and 284-66-203. Medicare supplement insurance policies must return to policyholders in the form of aggregated benefits under the policy, for the entire period for which rates are computed to provide coverage, loss ratios not less than those in this section. The loss ratios must be on the basis of incurred claims losses and earned premiums for such period according to accepted actuarial principles. The loss ratio standards of this section are more stringent and more appropriate than those imposed by RCW

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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, the loss ratios must be on the basis of incurred health care expenses and earned premiums for the period.

(2) All filings of rates and rating schedules must 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 must 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 rating period for the policy is reasonable according to accepted actuarial principles and experience. If the initial rating period for the policy is more than one year, ratios of incurred losses to earned premiums must be filed by number of years of policy duration. Supporting documentation must 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 must include claims paid and the change in claim reserves and liabilities. Incurred losses may 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. Where coverage is provided by a health care service contractor or health maintenance organization, health care expense costs may not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, and 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 rating period complies with the requirements of this section, relying on the judgment of the pricing actuary and acceptable to the commissioner; and

(c) For purposes of rate making and rate adjustments, similar policy forms must 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.

(d) 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 are expected to return to a policyholder in the form of aggregated loss ratios under the policy, at least sixty-five percent

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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 maintenance organizations and health care service contractors is 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-200, filed 8/4/05, effective 9/4/05. 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 before 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 in WAC 284-66-243(7).

(b) A medicare supplement policy form or certificate form may 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 the period, according to accepted actuarial principles and practices.

(c) All filing of rates and rating schedules must 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 must 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.

(e) For policies issued before April 28, 1996, expected claims in relation to premiums must meet:

(i) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(ii) The appropriate loss ratio requirement from WAC 284-66-203 (1)(b)(i) and (ii) when combined with actual experience beginning with April 28, 1996, to date; and

(iii) The appropriate loss ratio requirement from WAC 284-66-203 (1)(b)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

(iv) In meeting the tests in (e)(i), (ii), and (iii) of this subsection, and for purposes of attaining credibility, with the prior written approval of the commissioner, an issuer may combine experience under policy forms that provide substantially similar coverage. Once a combined form is adopted, the issuer may not separate the experience, except with the prior written approval of the commissioner.

(2) Refund or credit calculation.

(a) An issuer must 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 must be done on a statewide 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 must be excluded. This subsection applies only to annual experience reporting. Any revision of premium rates must be filed with and approved by the commissioner according to WAC 284-66-243.

(c) For policies or certificates issued before July 1, 1992, the issuer must make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the effective date of this section. The first report is due by May 31, 1998.

(d) A refund or credit may 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. The refund must 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 may it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due must be made by September 30 following the experience year that is the basis for the refund or credit.

(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 according to WAC 284-66-063, must 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 must also demonstrate, according to 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. The demonstration must exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years.

(4) As soon as practicable, but before the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state must file with the commissioner, according to 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. The supporting documents as necessary to justify the adjustment must accompany the filing.

(ii) An issuer must make any premium adjustments as are necessary to produce an expected loss ratio under the policy or certificate to comply with minimum loss ratio standards for medicare supplement policies and that 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 the medicare supplement policies or certificates. No premium adjustment that 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 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. The riders, endorsements, or policy forms must 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 consideration of any refund or credit for the reporting period. Public notice of the hearing must be furnished in a manner deemed appropriate by the commissioner.

(b) This section does not in any way restrict a commissioner'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 ___(year)___ reported by duration for all business from inception to December 31, 20____.				
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).]				
Policy <u>Duration</u>	Incurred <u>Losses</u>	Earned <u>Premiums</u>	Loss <u>Ratio</u>	Claim <u>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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-203, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-203, filed 4/11/96, effective 5/12/96. 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 applies to every group and individual policy of an issuer that 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 that 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 must 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 that 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 must 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. The adjustments must 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 must include a reasonable margin for the risk of adverse selection.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-210, filed 8/4/05, effective 9/4/05. 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 must be filed with the commissioner annually by 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-220, filed 8/4/05, effective 9/4/05. 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 Total Actual Incurred Claims (line 3, col b) Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6) = 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 Ratio 3 = Ratio 2 + 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.		
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) - Adjusted Incurred Claims (line 12) Benchmark Ratio (Ratio 1) 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 _____

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

(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
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: $(1 + n) / (k + m)$:

(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.

[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) All policy forms issued or delivered on or after January 1, 1990, and before July 1, 1992, as well as any future rate adjustments to such forms, must demonstrate compliance with the loss ratio requirements of WAC 284-66-200 and policy reserve requirements of WAC 284-66-210, unless the forms meet the standards of WAC 284-66-063 and 284-66-203. All filings of rate adjustments must 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 used by the pricing actuary, the commissioner may waive the requirements upon request of the issuer.

(a) Filings of issue age level premium rates must 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, the 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 must 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, the 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 must make premium adjustments that are necessary to produce an expected loss ratio under the policy that will conform with the minimum loss ratio standards of WAC 284-66-200.

(3) No premium adjustment that 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 must 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-240, filed 8/4/05, effective 9/4/05. 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 may 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 according to the filing requirements and procedures prescribed by the commissioner.

(2) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state that the policy or certificate was issued.

(3) An issuer may 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 according to the filing requirements and procedures prescribed by the commissioner.

(4)(a) Except as provided in (b) of this subsection, an issuer may 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. The form number for products offered to enrollees who are eligible by reason of disability must be distinct from the form number used for a corresponding standardized plan offered to an enrollee eligible for medicare by reason of age.

(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.

(5)(a) Except as provided in (a)(i) of this subsection, an issuer must 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 is not 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 before discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the

issuer may 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 under (a)(i) of this subsection, may 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 is considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology is 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 that 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 that is in the public interest.

(6)(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 must be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

(b) Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

(7) An issuer may set rates only on a community rated basis or on an issue-age level premium basis for policies issued prior to January 1, 1996, and may set rates only on a community rated basis for policies issued after December 31, 1995.

(a) For policies issued prior to January 1, 1996, community rated premiums must be equal for all individual policyholders or certificateholders under a standardized medicare supplement benefit form. Such premiums may not vary by age or sex. For policies issued after December 31, 1995, community rated premiums must be set according to RCW 48.66.045(3).

(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.

(8) All filings of policy or certificate forms must 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 and the actual loss ratios in comparison to the expected loss ratios stated in the initial rate filing on a calendar year basis by duration if applicable;

(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. The agreements must 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-243, filed 8/4/05, effective 9/4/05. 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 284-66-247 Interim rate and form filing requirements for standardized plans H, I and J and pre-standardized plans that include outpatient prescription drug benefits. The requirements of this section are in addition to all medicare supplement rate and form filing requirements set forth in this chapter.

(1) Form filings.

(a) To comply with the requirements of WAC 284-66-243(2), issuers are encouraged to use a generic rider or amendment that is bracketed for the purpose of identifying the modified policy forms. Riders or amendments may be used only for policies or certificates issued prior to January 1, 2006, and must be accompanied by a complete listing of the form numbers for all affected policies or certificates.

(b) After December 31, 2005, plans H, I, and J may not be issued to new enrollees using a rider or amendment to delete the outpatient prescription drug benefit. After that date, issuers must:

(i) Offer only new plans that are otherwise identical to their currently approved plans H, I, and J, with the outpatient prescription drug benefit removed. The new plans must incorporate all endorsements that have been previously approved by the commissioner.

(ii) Identify the new plan using the same form number as the currently approved corresponding plan, adding a unique identifier to the form number that distinguishes it from the plan with outpatient drug benefits.

(iii) Certify that the new plan, including any previously approved endorsements, is identical to the currently approved

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plan in all respects except for the deletion of the prescription drug benefit. The certification must be signed by an officer of the company.

(2) Rate filings.

(a) An issuer must submit revised rates for all policies or certificates that are modified using a rider or amendment to remove outpatient prescription drug coverage. The rates must be accompanied by an actuarial memorandum signed by a qualified actuary as defined in WAC 284-05-060 and include no less than the following information:

(i) The form number of the rider or amendment being used to modify the policy or certificate along with form number of the applicable policy or certificate.

(ii) If the modification applies to a prestandardized plan, a detailed description of the deleted prescription benefits.

(iii) A description and calculation of how the rate modification was determined including the general description and source of each assumption used.

(iv) A separate rate page listing the current rate charged for the underlying plan, the rate adjustment for the deleted outpatient drug benefit, and the final rate.

(b) An issuer must submit rates for standardized plans H, I, and J that will be issued after December 31, 2005. The rates must be consistent with the rates filed for the corresponding plans H, I and J that have been modified by rider or amendment to remove the outpatient prescription drug benefit and include all the current requirements for medicare supplement rate filings noted in this chapter.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-247, filed 8/4/05, effective 9/4/05.]

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 must 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, according to the filing requirements and procedures that apply to medicare supplement policies issued in this state.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-250, filed 8/4/05, effective 9/4/05. 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 according to 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 that 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

[Title 284 WAC—p. 371]

changes to the minimum benefit standards or other contractual benefits required by this chapter or as amended:

(a) An amendment to a medicare supplement insurance policy or certificate that 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 must be set forth in the policy.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-260, filed 8/4/05, effective 9/4/05. 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 must 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 that all claims may be sent by medicare carriers.

(2) Compliance with the requirements set forth in subsection (1) of this section must be certified on the medicare supplement insurance experience reporting form.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-270, filed 8/4/05, effective 9/4/05. 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 before use in this state, every issuer who provides medicare supplement insurance coverage to a resident of this state must 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 must be supplied on request of the commissioner.

(2) Advertising must comply with the standards of the Washington disability advertising regulation (WAC 284-50-010 through 284-50-230), and must identify 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-300, filed 8/4/05, effective 9/4/05. 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. The commissioner has found and 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 with respect to medicare supplement insurance. Accordingly, the rating practice commonly referred to as "attained age rating" is prohibited.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-310, filed 8/4/05, effective 9/4/05. 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 must 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-320, filed 8/4/05, effective 9/4/05. 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.

Table with 2 columns: 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, must:

- (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, keep, 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 that 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-330, filed 8/4/05, effective 9/4/05. 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 must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of a medicare supplement policy or certificate that will provide an individual more than one medicare supplement policy or certificate is prohibited.

(3) An issuer may not issue a medicare supplement policy or certificate to an individual enrolled in medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-340, filed 8/4/05, effective 9/4/05. 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 and 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 that 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 the coverage.

(b) Each commission payment must be made by the issuer no later than sixty days following the date on which the applicable premiums, that are the basis of the commission calculation, were paid. Each 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 must be designated by the issuer in its various agents' commission agreements and it may not terminate, reduce or keep 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 must 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 the 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 does 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.

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[Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-350, filed 8/4/05, effective 9/4/05. 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 may 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 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-400, filed 8/4/05, effective 9/4/05. 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.
284-74-020	Annuity 2000 and 1994 GAR tables.
284-74-100	Smoker/nonsmoker mortality tables.
284-74-200	Gender blended mortality tables for certain life insurance policies.
284-74-300	Purpose.
284-74-310	Authority.
284-74-320	Applicability.
284-74-330	Definitions.
284-74-340	General calculation requirements for basic reserves and premium deficiency reserves.
284-74-350	Calculation of minimum valuation standard for policies with nonlevel guaranteed maximum gross premiums or nonlevel guaranteed minimum benefits (other than universal life policies).
284-74-360	Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policy owner to keep a policy in force over a secondary guarantee period.
284-74-370	Operative date.
284-74-380	Select mortality factors.
284-74-400	Purpose.
284-74-410	Definitions.
284-74-420	2001 CSO mortality table.
284-74-430	Conditions.
284-74-440	Applicability to WAC 284-74-300 through 284-74-380.
284-74-450	Gender blended tables.
284-74-460	Effective date.

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, except as otherwise provided in WAC 284-74-020.

(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 Commission-

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ers (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 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 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, 98-05-069 (Matter No. R 97-5), § 284-74-010, filed 2/17/98, effective 3/20/98; 87-05-046 (Order R 87-3), § 284-74-010, filed 2/18/87.]

WAC 284-74-020 Annuity 2000 and 1994 GAR tables. The purpose of this section is to recognize the following mortality tables for use in determining the minimum standard of valuation for annuity and pure endowment contracts: The annuity 2000 mortality table, and the 1994 group annuity reserving (1994 GAR) table.

(1) This section does not apply to an individual annuity or pure endowment contract, if the contract is based on life contingencies and is issued to fund periodic benefits arising from:

(a) Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

(b) Settlements involving similar actions such as worker's compensation claims; or

(c) Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

(2) The annuity 2000 mortality table, which was developed by the society of actuaries committee on life insurance research and adopted as a recognized mortality table for annuities in December 1996 by the National Association of Insurance Commissioners (NAIC), and which is set forth in *Transactions, Society of Actuaries*, Vol. XLVII (1995), p. 240, is recognized and approved as an individual annuity mortality table for valuation and shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after April 1, 1998. At the option of the company, the annuity 2000 mortality table may be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1998.

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(3) The 1994 GAR table, which was developed by the society of actuaries group annuity valuation table task force and adopted as a recognized mortality table for annuities in December 1996 by the NAIC, and which is set forth in *Transactions, Society of Actuaries*, Vol. XLVII (1995), pp. 866 and 867, is recognized and approved as a group annuity mortality table for valuation and shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after April 1, 1998, under a group annuity or pure endowment contract. At the option of the company, the 1994 GAR table may be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1998, under a group annuity or pure endowment contract.

(4) In using the 1994 GAR table, the mortality rate for a person age x in year $(1994 + n)$ is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n,$$

where the q_x^{1994} and AA_x s are as specified in the 1994 GAR table.

[Statutory Authority: RCW 48.02.060, 98-05-069 (Matter No. R 97-5), § 284-74-020, filed 2/17/98, effective 3/20/98.]

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 commission-

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ers 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.]

WAC 284-74-300 Purpose. (1) The purpose of this regulation, WAC 284-74-300 through 284-74-380 is to provide:

- (a) Tables of select mortality factors and rules for their use;
- (b) Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and

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(c) Rules concerning a minimum standard for the valuation of plans with secondary guarantees.

(2) The method for calculating reserves defined in this regulation will constitute the commissioner's reserve valuation method for policies to which this regulation is applicable.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-300, filed 3/13/00, effective 4/13/00.]

WAC 284-74-310 Authority. This regulation is issued under the authority of RCW 48.02.060(3), 48.12.030(3), 48.74.040(1), 48.74.080 and 48.74.030 (1)(a)(iii).

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-310, filed 3/13/00, effective 4/13/00.]

WAC 284-74-320 Applicability. This regulation shall apply to all life insurance policies, with or without nonforfeiture values, issued on or after the operative date of this regulation, subject to the following exceptions and conditions.

(1)(a) This regulation shall not apply to any individual life insurance policy issued on or after the operative date of this regulation if the policy is issued in accordance with and as a result of the exercise of a reentry provision contained in the original life insurance policy of the same or greater face amount, issued before the operative date of this regulation, that guarantees the premium rates of the new policy. This regulation also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(b) This regulation shall not apply to any universal life insurance policy that meets all the following requirements:

(i) The secondary guarantee period, if any, is five years or less;

(ii) The specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables as defined in WAC 284-74-330(6) and the applicable valuation interest rate; and

(iii) The initial surrender charge is not less than one hundred percent of the first year annualized specified premium for the secondary guarantee period.

(c) This regulation shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(d) This regulation shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(e) This regulation shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(2)(a) Calculation of the minimum valuation standard for policies with gross premiums subject to a nonlevel guaranteed maximum or with benefits subject to a nonlevel guaranteed minimum (other than universal life policies), or both, shall be in accordance with the provisions of WAC 284-74-350.

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(b) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period, shall be in accordance with the provisions of WAC 284-74-360.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-320, filed 3/13/00, effective 4/13/00.]

WAC 284-74-330 Definitions. For purposes of this regulation:

(1) "Basic reserves" means reserves calculated in accordance with RCW 48.74.040(1).

(2) "Contract segmentation method" means the method of dividing the period from issue to mandatory expiration of a policy into successive segments, with the length of each segment being defined as the period from the end of the prior segment (from policy inception, for the first segment) to the end of the latest policy year as determined below. All calculations are made using the 1980 CSO valuation tables, as defined in subsection (6) of this section (or any other valuation mortality table adopted by the National Association of Insurance Commissioners (NAIC) after the operative date of this regulation and promulgated by regulation by the commissioner for this purpose), and, if elected for the plan, the optional minimum mortality standard for deficiency reserves stipulated in WAC 284-74-340(2).

The length of a particular contract segment shall be set equal to the minimum of the value t for which G_t is greater than R_t (if G_t never exceeds R_t , the segment length is deemed to be the number of years from the beginning of the segment to the mandatory expiration date of the policy), where G_t and R_t are defined as follows:

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

where:

- x = original issue age;
- k = the number of years from the date of issue to the beginning of the segment;
- t = 1, 2, ...; t is reset to 1 at the beginning of each segment;

$GP_{x+k+t-1}$ = Guaranteed maximum gross premium per thousand of face amount for year t of the segment, ignoring policy fees only if level for the premium paying period of the policy.

$$R_t = \frac{q_{x+k+t}}{q_{x+k+t-1}}$$

However, R_t may be increased or decreased by one percent in any policy year, at the company's option, but R_t shall not be less than one;

where: x , k and t are as defined above, and $q_{x+k+t-1}$ = valuation mortality rate for deficiency reserves in policy year $k+t$ but using the mortality of WAC 284-74-340 (2)(b) if WAC 284-74-340 (2)(c) is elected for deficiency reserves.

However, if GP_{x+k+t} is greater than 0 and $GP_{x+k+t-1}$ is equal to 0, G_t shall be deemed to be 1000. If GP_{x+k+t} and $GP_{x+k+t-1}$ are both equal to 0, G_t shall be deemed to be 0.

(3) "Deficiency reserves" means the excess, if greater than zero, of

(a) Minimum reserves calculated in accordance with RCW 48.74.070 over

(b) Basic reserves.

(4) "Guaranteed maximum gross premiums" means the premiums guaranteed and determined at issue that the actual gross premiums under a policy of life insurance cannot exceed.

(5) "Maximum valuation interest rates" means the interest rates defined in RCW 48.74.030(3) that are to be used in determining the minimum standard for the valuation of life insurance policies.

(6) "1980 CSO valuation tables" means the commissioners 1980 standard ordinary mortality table (1980 CSO table) without ten-year select mortality factors, incorporated into the 1980 amendments to the NAIC model standard valuation law, and variations of the 1980 CSO table approved by the NAIC, such as the smoker and nonsmoker versions approved in December 1983.

(7) "Scheduled gross premium" means the smallest illustrated gross premium at issue for other than universal life insurance policies. For universal life insurance policies, scheduled gross premium means the smallest specified premium described in WAC 284-74-360 (1)(c), if any, or else the minimum premium described in WAC 284-74-360 (1)(d).

(8)(a) "Segmented reserves" means reserves, calculated using segments produced by the contract segmentation method, equal to the present value of all future guaranteed benefits less the present value of all future net premiums to the mandatory expiration of a policy, where the net premiums within each segment are a uniform percentage of the respective guaranteed maximum gross premiums within the segment. The uniform percentage for each segment is such that, at the beginning of the segment, the present value of the net premiums within the segment equals:

(i) The present value of the death benefits within the segment, plus

(ii) The present value of any unusual guaranteed cash value (see WAC 284-74-350(4)) occurring at the end of the segment, less

(iii) Any unusual guaranteed cash value occurring at the start of the segment, plus

(iv) For the first segment only, the excess of the item (A) over item (B), as follows:

(A) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for in the first segment after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary within the first segment on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(B) A net one year term premium for the benefits provided for in the first policy year.

(b) The length of each segment is determined by the contract segmentation method, as defined in this section.

(c) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the sum of the lengths of all segments of the policy.

(d) For both basic reserves and deficiency reserves computed by the segmented method, present values shall include future benefits and net premiums in the current segment and in all subsequent segments.

(9) "Tabular cost of insurance" means the net single premium at the beginning of a policy year for one-year term insurance in the amount of the guaranteed death benefit in that policy year.

(10) "Ten-year select mortality factors" means the select factors adopted with the 1980 amendments to the NAIC standard valuation law.

(11)(a) "Unitary reserves" means the present value of all future guaranteed benefits less the present value of all future modified net premiums, where:

(i) Guaranteed benefits and modified net premiums are considered to the mandatory expiration of the policy; and

(ii) Modified net premiums are a uniform percentage of the respective guaranteed maximum gross premiums, where the uniform percentage is such that, at issue, the present value of the net premiums equals the present value of all death benefits and pure endowments, plus the excess of item (A) over item (B), as follows:

(A) A net level annual premium equal to the present value, at the date of issue, of the benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one year higher than the age at issue of the policy.

(B) A net one year term premium for the benefits provided for in the first policy year.

(b) The interest rates used in the present value calculations for any policy may not exceed the maximum valuation interest rate, determined with a guarantee duration equal to the length from issue to the mandatory expiration of the policy.

(12) "Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality or expense charges are made to the policy.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-330, filed 3/13/00, effective 4/13/00.]

WAC 284-74-340 General calculation requirements for basic reserves and premium deficiency reserves. (1) At the election of the company for any one or more specified plans of life insurance, the minimum valuation standard of mortality under RCW 48.74.030(1) for basic reserves may be calculated using the 1980 CSO mortality table with select mortality factors (or any other valuation mortality table

adopted by the NAIC after the operative date of this regulation and promulgated by regulation by the commissioner for this purpose). If select mortality factors are elected, they may be:

(a) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC standard valuation law;

(b) The select mortality factors in WAC 284-74-380; or

(c) Any other table of select mortality factors adopted by the NAIC after the operative date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating basic reserves.

(2) Deficiency reserves, if any, are calculated under RCW 48.74.070 for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using the minimum valuation standards of mortality under RCW 48.74.030(1) and rate of interest under RCW 48.74.030 (3), and replacing the net premium by the actual gross premium in each contract year the actual gross premium is less than the corresponding net premium. The actual gross premiums shall be the maximum gross premiums guaranteed on the valuation date.

The quantity A and the corresponding net premiums used in the determination of quantity A shall be based upon the minimum valuation standard of mortality under subsection (1) of this section for basic reserves: Provided, That at the election of the company for any one or more specified plans of life insurance, the quantity A and the corresponding net premiums used in the determination of the quantity A may be based upon the 1980 CSO mortality table with select mortality factors (or any other valuation mortality table adopted by the NAIC after the operative date of this regulation and promulgated by regulation by the commissioner). If select mortality factors are elected, they may be:

(a) The ten-year select mortality factors incorporated into the 1980 amendments to the NAIC standard valuation law;

(b) The select mortality factors in WAC 284-74-380;

(c) Subject to the conditions in subsection (3) of this section, X percent of the select mortality factors in WAC 284-74-380; or

(d) Any other table of select mortality factors adopted by the NAIC after the operative date of this regulation and promulgated by regulation by the commissioner for the purpose of calculating deficiency reserves.

(3) If X percent of the select mortality factors in WAC 284-74-380 is elected under subsection (2)(c) of this section, then that election is subject to the following conditions:

(a) X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

(b) X shall not be less than twenty percent;

(c) X shall not decrease in any successive policy years;

(d) Using the valuation interest rate for basic reserves, subparagraph (i) is greater than or equal to subparagraph (ii);

(i) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(ii) The actuarial present value of future death benefits, calculated using anticipated mortality experience without

recognition of mortality improvement beyond the valuation date;

(e) The mortality rates resulting from the application of X are at least as great as anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

(f) The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of this subsection (3);

(g) The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of this subsection (3); and

(h) The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

(i) If X is less than one hundred percent at any duration for any policy, the following requirements shall be met:

(i) The appointed actuary shall annually prepare an actuarial opinion and memorandum in conformance with the requirements of WAC 284-07-380 through 284-07-400; and

(ii) The appointed actuary shall annually opine for all policies subject to this regulation as to whether the mortality rates resulting from the application of X meet the requirements of this subsection (3). This opinion shall be included with or attached to the company's annual statement, and shall disclose the lowest X factor used for any policy on the valuation date. This opinion shall be supported by an actuarial report, subject to appropriate actuarial standards of practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

(4) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than ten years, the appropriate ten-year select mortality factors incorporated into the 1980 amendments to the NAIC standard valuation law may be used thereafter through the tenth policy year from the date of issue.

(5) In determining basic reserves or deficiency reserves, guaranteed maximum gross premiums without policy fees may be used where the calculation involves the guaranteed maximum gross premium but only if the policy fee is specified in the policy and is a level dollar amount for the entire premium paying period of the policy. In determining deficiency reserves, policy fees may be included in guaranteed maximum gross premiums, even if not included in the actual calculation of basic reserves.

(6) Reserves for policies under which the insurer has changed its guarantees after issue with respect to gross premiums, benefits, charges, or credits, with the new guarantees effective for more than one year after the date of the change, shall be the greatest of the following:

(a) Reserves calculated ignoring the change;

(b) Reserves assuming the guarantee was made at issue; and

(c) Reserves assuming that the policy was issued on the date of the guarantee.

(7) The commissioner may require that the company document the extent of the adequacy of reserves for specified blocks, including, but not limited to, policies issued prior to the operative date of this regulation. This documentation may include a demonstration of the extent to which aggregation with other nonspecified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of WAC 284-07-380 and 284-07-400.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-340, filed 3/13/00, effective 4/13/00.]

WAC 284-74-350 Calculation of minimum valuation standard for policies with nonlevel guaranteed maximum gross premiums or nonlevel guaranteed minimum benefits (other than universal life policies).

(1) Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and select mortality factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in (a) or (b) of this subsection may be made:

(a) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2)(a) The deficiency reserve at any duration shall be calculated:

(i) On a unitary basis if the corresponding basic reserve determined by subsection (1) of this section is unitary;

(ii) On a segmented basis if the corresponding basic reserve determined by subsection (1) of this section is segmented; or

(iii) On the segmented basis if the corresponding basic reserve determined by subsection (1) of this section is equal to both the segmented reserve and the unitary reserve.

(b) This subsection shall apply to any policy for which the guaranteed maximum gross premium or actual gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified in WAC 284-074-340(2)) and rate of interest.

(c) Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in WAC 284-74-340(2).

(d) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(3) Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves

are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if midterminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as those used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten-year select mortality factors incorporated into the 1980 amendments to the NAIC standard valuation law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policy owner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(4)(a) For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(b) The reserves actually held subsequent to any unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the policy as an n year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

(i) n is the number of years from the date of the last unusual guaranteed cash surrender value prior to the valuation date to the earlier of:

(A) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or
(B) The mandatory expiration date of the policy; and

(ii) The net premium for a given year during the n year period is equal to the product of the net to gross ratio and the respective gross premium; and

(iii) The net to gross ratio is equal to item (A) divided by item (B) as follows:

(A) The present value, at the beginning of the n year period, of death benefits payable during the n year period plus the present value, at the beginning of the n year period, of the next unusual guaranteed cash surrender value, if any, minus the amount of the last unusual guaranteed cash surrender value, if any, scheduled at the beginning of the n year period.

(B) The present value, at the beginning of the n year period, of the scheduled gross premiums payable during the n year period.

(c) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(i) One hundred ten percent of the scheduled gross premium for that year;

(ii) One hundred ten percent of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(iii) Five percent of the first policy year surrender charge, if any.

(5) At the option of the company, the following approach for reserves on yearly renewal term reinsurance may be used:

(a) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(b) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (3) of this section.

(c) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective guaranteed maximum gross premium.

(d) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with (c) of this subsection.

(e) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality table with or without ten-year select mortality factors, or any other table adopted after the operative date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(f) A reinsurance agreement shall be considered yearly renewable term reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(g) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit shall be limited to the amount of reserve held by the assuming company for the affected policies.

(6) At the option of the company, the following approach for reserves for attained-age-based yearly renewable term life insurance policies may be used:

(a) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(b) Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (3) of this section.

(c) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective guaranteed maximum gross premium.

(d) Deficiency reserves shall never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with (c) of this subsection.

(e) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the operative date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(f) A policy shall be considered an attained-age-based yearly renewable term life insurance policy for purposes of this subsection if:

(i) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are based upon the attained age of the insured such that the rate

for any given policy at a given attained age of the insured is independent of the year the policy was issued; and

(ii) The premium rates (on both the initial current premium scale and the guaranteed maximum premium scale) are the same as the premium rates for policies covering all insureds of the same sex, risk class, plan of insurance and attained age.

(g) For policies that become attained-age-based yearly renewable term policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(i) The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(ii) The initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(iii) After the initial period of coverage, the policy meets the conditions of (f) of this subsection.

(h) If this election is made, this approach shall be applied in determining reserves for all attained-age-based yearly renewable term life insurance policies issued on or after the operative date of this regulation.

(7) Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met:

(a) The policy consists of a series of n-year periods, including the first period and all renewal periods, where n is the same for each period, except that for the final renewal period, n may be truncated or extended to reach the expiry age: Provided, That this final renewal period is less than ten years and less than twice the size of the earlier n-year periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(b) The guaranteed maximum gross premiums in all n-year periods are not less than the corresponding net premiums based upon the 1980 CSO mortality table with or without the ten-year select mortality factors; and

(c) There are no cash surrender values in any policy year.

(8) Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met, based upon the initial current premium scale at issue:

(a) At issue, the insured is age twenty-four or younger;

(b) Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five, the gross premiums and death benefits are level, and there are no cash surrender values; and

(c) After the end of the juvenile period, gross premiums are level for the remainder of the premium paying period, and death benefits are level for the remainder of the life of the policy.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-350, filed 3/13/00, effective 4/13/00.]

WAC 284-74-360 Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policy owner to keep a policy in force over a secondary guarantee period. (1)(a) Policies with a secondary guarantee include:

(i) A policy with a guarantee that the policy will remain in force at the original schedule of benefits over a specified period of time, subject only to the payment of specified premiums;

(ii) A policy in which the minimum premium at any duration is less than the corresponding one year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the operative date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose; or

(iii) A policy with any combination of (a)(i) and (ii) of this subsection.

(b) A secondary guarantee period is the period for which the policy is guaranteed to remain in force subject only to a secondary guarantee. When a policy contains more than one secondary guarantee, the minimum reserve shall be the greatest of the respective minimum reserves at that valuation date of each unexpired secondary guarantee, ignoring all other secondary guarantees. Secondary guarantees that are unilaterally changed by the insurer after issue shall be considered to have been made at issue. Reserves described in subsections (2) and (3) of this section shall be recalculated from issue to reflect these changes.

(c) Specified premiums mean the premiums specified by the insurer, the payment of which guarantees that the policy will remain in force at the original schedule of benefits, but which otherwise would be insufficient to keep the policy in force in the absence of the guarantee if maximum mortality and expense charges and minimum interest credits were made and any applicable surrender charges were assessed.

(d) For purposes of this section, the minimum premium for any policy year is the premium that, when paid into a policy with a zero account value at the beginning of the policy year, produces a zero account value at the end of the policy year. The minimum premium calculation shall use the policy cost factors (including mortality charges, loads and expense charges) and the interest crediting rate, which are all guaranteed at issue.

(e) The one-year valuation premium means the net one-year premium based upon the original schedule of benefits for a given policy year. The one-year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in WAC 284-74-340 (2)(b), (c) and (d) may not be used to calculate the one-year valuation premiums.

(f) The one-year valuation premium should reflect the frequency of fund processing, as well as the distribution of deaths assumption employed in the calculation of the monthly mortality charges to the fund.

(2) Basic reserves for the secondary guarantees shall be the segmented reserves for the secondary guarantee period. In calculating the segments and the segmented reserves, the gross premiums shall be set equal to the specified premiums, if any, or otherwise to the minimum premiums, that keep the policy in force and the segments will be determined according to the contract segmentation method as defined in WAC 284-74-330(2).

(3) Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in WAC 284-74-350(2) with gross premiums set equal to the specified premiums, if any,

or otherwise to the minimum premiums that keep the policy in force.

(4) The minimum reserves during the secondary guarantee period are the greater of:

(a) The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or

(b) The minimum reserves required by other statutory provisions, rules or regulations governing universal life plans.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-360, filed 3/13/00, effective 4/13/00.]

WAC 284-74-370 Operative date. On or after the effective date of this regulation, the company to whose policies this regulation applies may elect January 1, 2000, as its operative date. If the company makes no such election, this regulation shall become operative on its effective date.

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-370, filed 3/13/00, effective 4/13/00.]

WAC 284-74-380 Select mortality factors. This section contains the tables of select mortality factors to which WAC 284-74-340 (1)(b), (2)(b) and (c) refer. The factors in this section are percentages to be applied to the 1980 CSO valuation tables.

The six tables of select mortality factors contained herein include:

- (1) Male composite;
- (2) Male nonsmoker;
- (3) Male smoker;
- (4) Female composite;
- (5) Female nonsmoker; and
- (6) Female smoker.

The same factors apply to both age last birthday and age nearest birthday mortality tables.

(1) The select mortality factors for male composite are as shown in the table below:

Male Composite - Select Mortality Factors																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	96	98	98	99	99	100	100	90	92	92	92	92	93	93	96	97	98	98	99	100
19	83	84	84	87	87	87	79	79	79	81	81	82	82	82	85	88	91	94	97	100
20	69	71	71	74	74	69	69	67	69	70	71	71	71	71	74	79	84	90	95	100
21	66	68	69	71	66	66	67	66	67	70	70	70	70	71	71	77	83	88	94	100
22	65	66	66	63	63	64	64	64	65	68	68	68	68	69	71	77	83	88	94	100
23	62	63	59	60	62	62	63	63	64	65	65	67	67	69	70	76	82	88	94	100
24	60	56	56	59	59	60	61	61	61	64	64	64	66	67	70	76	82	88	94	100
25	52	53	55	56	58	58	60	60	60	63	62	63	64	67	69	75	81	88	94	100
26	51	52	55	56	58	58	57	61	61	62	63	64	66	69	66	73	80	86	93	100
27	51	52	55	57	58	60	61	61	60	63	63	64	67	66	67	74	80	87	93	100
28	49	51	56	58	60	60	61	62	62	63	64	66	65	66	68	74	81	87	94	100
29	49	51	56	58	60	61	62	62	62	64	64	62	66	67	70	76	82	88	94	100
30	49	50	56	58	60	60	62	63	63	64	62	63	67	68	71	77	83	88	94	100
31	47	50	56	58	60	62	63	64	64	62	63	66	68	70	72	78	83	89	94	100
32	46	49	56	59	60	62	63	66	62	63	66	67	70	72	73	78	84	89	95	100
33	43	49	56	59	62	63	64	62	65	66	67	70	72	73	75	80	85	90	95	100
34	42	47	56	60	62	63	61	63	66	67	70	71	73	75	76	81	86	90	95	100
35	40	47	56	60	63	61	62	65	67	68	71	73	74	76	76	81	86	90	95	100
36	38	42	56	60	59	61	63	65	67	68	70	72	74	76	77	82	86	91	95	100
37	38	45	56	57	61	62	63	65	67	68	70	72	74	76	76	81	86	90	95	100
38	37	44	53	58	61	62	65	66	67	69	69	73	75	76	77	82	86	91	95	100
39	37	41	53	58	62	63	65	65	66	68	69	72	74	76	76	81	86	90	95	100
40	34	40	53	58	62	63	65	65	66	68	68	71	75	76	77	82	86	91	95	100
41	34	41	53	58	62	63	65	64	64	66	68	70	74	76	77	82	86	91	95	100
42	34	43	53	58	61	62	63	63	63	64	66	69	72	75	77	82	86	91	95	100
43	34	43	54	59	60	61	63	62	62	64	66	67	72	74	77	82	86	91	95	100
44	34	44	54	58	59	60	61	60	61	62	64	67	71	74	77	82	86	91	95	100
45	34	45	53	58	59	60	60	60	59	60	63	66	71	74	77	82	86	91	95	100
46	31	43	52	56	57	58	59	59	59	60	63	67	71	74	75	80	85	90	95	100
47	32	42	50	53	55	56	57	58	59	60	65	68	71	74	75	80	85	90	95	100
48	32	41	47	52	54	56	57	57	57	61	65	68	72	73	74	79	84	90	95	100
49	30	40	46	49	52	54	55	56	57	61	66	69	72	73	74	79	84	90	95	100
50	30	38	44	47	51	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
51	28	37	42	46	49	53	54	56	57	61	66	71	72	73	75	80	85	90	95	100
52	28	35	41	45	49	51	54	56	57	61	66	71	72	74	75	80	85	90	100	100
53	27	35	39	44	48	51	53	55	57	61	67	71	74	75	76	81	86	100	100	100
54	27	33	38	44	48	50	53	55	57	61	67	72	74	75	76	81	100	100	100	100
55	25	32	37	43	47	50	53	55	57	61	68	72	74	75	78	100	100	100	100	100
56	25	32	37	43	47	49	51	54	56	61	67	70	73	74	100	100	100	100	100	100
57	24	31	38	43	47	49	51	54	56	59	66	69	72	100	100	100	100	100	100	100
58	24	31	38	43	48	48	50	53	56	59	64	67	100	100	100	100	100	100	100	100
59	23	30	39	43	48	48	51	53	55	58	63	100	100	100	100	100	100	100	100	100
60	23	30	39	43	48	47	50	52	53	57	100	100	100	100	100	100	100	100	100	100
61	23	30	39	43	49	49	50	52	53	75	100	100	100	100	100	100	100	100	100	100

Approved Insurance Tables

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Male Composite - Select Mortality Factors																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
62	23	30	39	44	49	49	51	52	75	75	100	100	100	100	100	100	100	100	100	100
63	22	30	39	45	50	50	52	75	75	75	100	100	100	100	100	100	100	100	100	100
64	22	30	39	45	50	51	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	22	30	39	45	50	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	22	30	49	45	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	22	30	39	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	23	32	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	23	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(2) The select mortality factors for male nonsmoker are as shown in the table below:

Male Nonsmoker - Select Mortality Factors																				
Issue	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	93	95	96	98	99	100	100	90	92	92	92	92	95	95	96	97	98	98	99	100
19	80	81	83	86	87	87	79	79	79	81	81	82	83	83	86	89	92	94	97	100
20	65	68	69	72	74	69	69	67	69	70	71	71	72	72	75	80	85	90	95	100
21	63	66	68	71	66	66	67	66	67	70	70	70	71	71	73	78	84	89	95	100
22	62	65	66	62	63	64	64	64	67	68	68	68	70	70	73	78	84	89	95	100
23	60	62	58	60	62	62	63	63	64	67	68	68	67	69	71	77	83	88	94	100
24	59	55	56	58	59	60	61	61	63	65	67	66	66	69	71	77	83	88	94	100
25	52	53	55	56	58	58	60	60	61	64	64	64	64	67	70	76	82	88	94	100
26	51	53	55	56	58	60	61	61	61	63	64	64	66	69	67	74	80	87	93	100
27	51	52	55	58	60	60	61	61	62	63	64	66	67	66	67	74	80	87	93	100
28	49	52	57	58	60	61	63	62	62	64	66	66	63	66	68	74	81	87	94	100
29	49	51	57	60	61	61	62	62	63	64	66	63	65	67	68	74	81	87	94	100
30	49	51	57	60	61	62	63	63	63	64	62	63	66	68	70	76	82	88	94	100
31	47	50	57	60	60	62	63	64	64	62	63	65	67	70	71	77	83	88	94	100
32	46	50	57	60	62	63	64	64	62	63	65	66	68	71	72	78	83	89	94	100
33	45	49	56	60	62	63	64	62	63	65	66	68	71	73	74	79	84	90	95	100
34	43	48	56	62	63	64	62	62	65	66	67	70	72	74	74	79	84	90	95	100
35	41	47	56	62	63	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
36	40	47	56	62	59	61	62	63	66	67	68	70	72	74	75	80	85	90	95	100
37	38	45	56	58	59	61	62	63	66	67	67	69	71	73	74	79	84	90	95	100
38	38	45	53	58	61	62	63	65	65	67	68	70	72	74	73	78	84	89	95	100
39	37	41	53	58	61	62	63	64	65	67	68	70	71	73	73	78	84	89	95	100
40	34	41	53	58	61	62	63	64	64	66	67	69	71	73	72	78	83	89	94	100
41	34	41	53	58	61	61	62	62	63	65	65	67	69	71	71	77	83	88	94	100
42	34	43	53	58	60	61	62	61	61	63	64	66	67	69	71	77	83	88	94	100
43	32	43	53	58	60	61	60	60	60	60	62	64	66	68	69	75	81	88	94	100
44	32	44	52	57	59	60	60	59	59	58	60	62	65	67	69	75	81	88	94	100
45	32	44	52	57	59	60	59	57	57	57	59	61	63	66	68	74	81	87	94	100
46	32	42	50	54	56	57	57	56	55	56	59	61	63	65	67	74	80	87	93	100
47	30	40	48	52	54	55	55	54	54	55	59	61	62	63	66	73	80	86	93	100
48	30	40	46	49	51	52	53	53	54	55	57	61	62	63	63	70	78	85	93	100
49	29	39	43	48	50	51	50	51	53	54	57	61	61	62	62	70	77	85	92	100
50	29	37	42	45	47	48	49	50	51	54	57	61	61	61	61	69	77	84	92	100
51	27	35	40	43	45	47	48	50	51	53	57	60	61	61	62	70	77	85	92	100
52	27	34	39	42	44	45	48	49	50	53	56	60	60	62	62	70	77	85	100	100
53	25	31	37	41	44	45	47	49	50	51	56	59	61	61	62	70	77	100	100	100
54	25	30	36	39	43	44	47	48	49	51	55	59	59	61	62	70	100	100	100	100
55	24	29	35	38	42	43	45	48	49	50	56	58	59	61	62	100	100	100	100	100
56	23	29	35	38	42	42	44	47	48	50	55	57	58	59	100	100	100	100	100	100
57	23	28	35	38	42	42	43	45	47	49	53	55	56	100	100	100	100	100	100	100

Male Nonsmoker - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
58	22	28	33	37	41	41	43	45	45	47	51	53	100	100	100	100	100	100	100	100
59	22	26	33	37	41	41	42	44	44	46	50	100	100	100	100	100	100	100	100	100
60	20	26	33	37	41	40	41	42	42	45	100	100	100	100	100	100	100	100	100	100
61	20	26	33	37	41	40	41	42	42	75	100	100	100	100	100	100	100	100	100	100
62	19	25	32	38	40	40	41	42	75	75	100	100	100	100	100	100	100	100	100	100
63	19	25	33	36	40	40	41	75	75	75	100	100	100	100	100	100	100	100	100	100
64	18	24	32	36	39	40	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	18	24	32	36	39	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	18	24	32	36	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	18	24	32	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	18	24	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	18	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(3) The select mortality factors for male smoker are as shown in the table below:

Male Smoker - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
19	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
20	98	100	100	100	100	100	100	99	99	99	100	99	99	99	100	100	100	100	100	100
21	95	98	99	100	95	96	96	95	96	97	97	96	96	96	96	97	98	98	99	100
22	92	95	96	90	90	93	93	92	93	95	95	93	93	92	93	94	96	97	99	100
23	90	92	85	88	88	89	89	89	90	90	90	90	89	90	92	94	95	97	98	100
24	87	81	82	85	84	86	88	86	86	88	88	86	86	88	89	91	93	96	98	100
25	77	78	79	82	81	83	83	82	83	85	84	84	84	85	86	89	92	94	97	100
26	75	77	79	82	82	83	83	82	83	84	84	84	84	85	81	85	89	92	96	100
27	73	75	78	82	82	83	83	82	82	82	82	84	84	84	80	81	85	89	92	96
28	71	73	79	82	81	82	83	81	81	82	82	82	80	80	81	85	89	92	96	100
29	69	72	78	81	81	82	82	81	81	81	81	77	80	80	81	85	89	92	96	100
30	68	71	78	81	81	81	82	81	81	81	76	77	80	80	81	85	89	92	96	100
31	65	70	77	81	79	81	82	81	81	76	77	79	81	81	83	86	90	93	97	100
32	63	67	77	78	79	81	81	81	76	77	77	80	83	83	85	88	91	94	97	100
33	60	65	74	78	79	79	81	76	77	77	79	80	83	85	85	88	91	94	97	100
34	57	62	74	77	79	79	75	76	77	79	79	81	83	85	87	90	92	95	97	100
35	53	60	73	77	79	75	75	76	77	79	80	82	84	86	88	90	93	95	98	100
36	52	59	71	75	74	75	75	76	77	79	79	81	83	85	87	90	92	95	97	100
37	49	58	70	71	74	74	75	76	77	78	79	81	84	86	86	89	92	94	97	100
38	48	55	66	70	72	74	74	75	76	78	79	81	83	85	87	90	92	95	97	100
39	45	50	65	70	72	72	74	74	75	77	79	81	84	86	86	89	92	94	97	100
40	41	49	63	68	71	72	73	74	74	76	78	80	83	85	86	89	92	94	97	100
41	40	49	63	68	71	72	72	72	73	75	76	78	81	84	85	88	91	94	97	100
42	40	49	62	68	70	71	71	71	71	73	75	76	81	83	85	88	91	94	97	100
43	39	50	62	67	69	69	70	70	70	71	73	76	79	83	85	88	91	94	97	100
44	39	50	60	66	68	69	68	69	69	69	71	74	79	81	85	88	91	94	97	100
45	37	50	60	66	68	68	68	67	67	67	69	73	78	81	85	88	91	94	97	100
46	37	48	58	63	65	67	66	66	66	67	71	74	78	81	84	87	90	94	97	100
47	36	47	55	61	63	64	64	64	65	67	71	75	79	81	84	87	90	94	97	100
48	35	46	53	58	60	62	63	63	65	67	72	75	79	81	83	86	90	93	97	100
49	34	45	51	56	58	59	61	62	63	67	72	77	80	81	83	86	90	93	97	100
50	34	43	49	53	55	57	60	61	63	67	73	78	80	81	81	85	89	92	96	100
51	32	42	47	52	55	57	60	61	63	67	73	78	80	83	84	87	90	94	97	100
52	32	40	46	50	54	56	60	61	63	67	73	78	81	84	85	88	91	94	100	100
53	30	37	44	49	54	56	59	61	65	67	74	79	83	85	87	90	92	100	100	100

Approved Insurance Tables

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Male Smoker - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
54	30	36	43	48	53	55	59	61	65	67	74	80	84	85	89	91	100	100	100	100
55	29	35	42	47	53	55	59	61	65	67	75	80	84	86	90	100	100	100	100	100
56	28	35	42	47	53	55	57	60	63	68	74	79	83	85	100	100	100	100	100	100
57	28	35	42	47	53	54	57	60	64	67	74	78	81	100	100	100	100	100	100	100
58	26	33	43	48	54	54	56	59	63	67	73	78	100	100	100	100	100	100	100	100
59	26	33	43	48	54	53	57	59	63	66	73	100	100	100	100	100	100	100	100	100
60	25	33	43	48	54	53	56	58	62	66	100	100	100	100	100	100	100	100	100	100
61	25	33	43	49	55	55	57	59	63	75	100	100	100	100	100	100	100	100	100	100
62	25	33	43	50	56	56	58	61	75	75	100	100	100	100	100	100	100	100	100	100
63	24	33	45	51	56	56	59	75	75	75	100	100	100	100	100	100	100	100	100	100
64	24	34	45	51	57	57	75	75	75	75	100	100	100	100	100	100	100	100	100	100
65	24	34	45	52	57	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
66	24	35	45	53	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
67	25	35	45	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
68	25	36	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
69	27	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
70	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
71	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
72	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
73	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
74	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
75	48	52	55	60	60	65	70	70	70	70	100	100	100	100	100	100	100	100	100	100
76	48	52	55	60	60	65	70	70	70	100	100	100	100	100	100	100	100	100	100	100
77	48	52	55	60	60	65	70	70	100	100	100	100	100	100	100	100	100	100	100	100
78	48	52	55	60	60	65	70	100	100	100	100	100	100	100	100	100	100	100	100	100
79	48	52	55	60	60	65	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	48	52	55	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	48	52	55	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	48	52	55	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	48	52	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	48	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(4) The select mortality factors for female composite are as shown in the table below:

Female Composite - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	99	100	100	100	100	100	100	100	93	95	96	97	97	100	100	100	100	100	100	100
18	83	83	84	84	84	84	86	78	78	79	82	84	85	88	88	90	93	95	98	100
19	65	66	68	68	68	68	63	63	64	66	69	71	72	74	75	80	85	90	95	100
20	48	50	51	51	51	47	48	48	49	51	56	57	58	61	63	70	78	85	93	100
21	47	48	50	51	47	47	48	49	51	53	57	60	61	64	64	71	78	86	93	100
22	44	47	48	45	47	47	48	49	53	54	60	61	63	64	66	73	80	86	93	100
23	42	45	44	45	47	47	49	51	53	54	61	64	64	67	69	75	81	88	94	100
24	39	40	42	44	47	47	50	51	54	56	64	64	66	69	70	76	82	88	94	100
25	34	38	41	44	47	47	50	53	56	57	64	67	69	71	73	78	84	89	95	100
26	34	38	41	45	49	49	51	56	58	59	66	69	70	73	70	76	82	88	94	100
27	34	38	41	47	50	51	54	57	59	60	69	70	73	70	71	77	83	88	94	100
28	34	37	43	47	53	53	56	59	62	63	70	73	70	72	74	79	84	90	95	100
29	34	38	43	49	54	56	58	60	63	64	73	70	72	74	75	80	85	90	95	100
30	35	38	43	50	56	56	59	63	66	67	70	71	74	75	76	81	86	90	95	100
31	35	38	43	51	56	58	60	64	67	65	71	72	74	75	76	81	86	90	95	100
32	35	39	45	51	56	59	63	66	65	66	72	72	75	76	76	81	86	90	95	100
33	36	39	44	52	58	62	64	65	66	67	72	74	75	76	76	81	86	90	95	100
34	36	40	45	52	58	63	63	66	67	68	74	74	76	76	76	81	86	90	95	100
35	36	40	45	53	59	61	65	67	68	70	75	74	75	76	75	80	85	90	95	100
36	36	40	45	53	55	62	65	67	68	70	74	74	74	75	75	80	85	90	95	100
37	36	41	47	52	57	62	65	67	68	69	72	72	73	75	74	79	84	90	95	100
38	34	41	44	52	57	63	66	68	69	70	72	71	72	74	75	80	85	90	95	100
39	34	40	45	53	58	63	66	68	69	69	70	70	70	73	74	79	84	90	95	100
40	32	40	45	53	58	65	65	67	68	69	70	69	70	73	73	78	84	89	95	100
41	32	40	45	53	57	63	64	67	68	68	69	69	69	73	74	79	84	90	95	100
42	32	40	45	52	56	61	63	65	66	68	69	68	70	74	75	80	85	90	95	100
43	31	39	45	51	55	59	61	65	65	66	68	69	69	74	77	82	86	91	95	100
44	31	39	45	50	54	58	61	63	64	66	67	68	71	75	78	82	87	91	96	100
45	31	38	44	49	53	56	59	62	63	65	67	68	71	77	79	83	87	92	96	100
46	29	37	43	48	51	54	59	62	63	65	67	69	71	77	78	82	87	91	96	100
47	28	35	41	46	49	54	57	61	62	66	68	69	71	77	77	82	86	91	95	100
48	28	35	41	44	49	52	57	61	63	66	68	71	72	75	77	82	86	91	95	100
49	26	34	39	43	47	52	55	61	63	67	69	71	72	75	75	80	85	90	95	100

Female Composite - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
50	25	32	38	41	46	50	55	61	63	67	69	72	72	75	74	79	84	90	95	100
51	25	32	38	41	45	50	55	61	63	66	68	69	71	74	74	79	84	90	95	100
52	23	30	36	41	45	51	56	61	62	65	66	68	68	73	73	78	84	89	100	100
53	23	30	36	41	47	51	56	61	62	63	65	66	68	72	72	78	83	100	100	100
54	22	29	35	41	47	53	57	61	61	62	62	66	66	69	70	76	100	100	100	100
55	22	29	35	41	47	53	57	61	61	61	62	63	64	68	69	100	100	100	100	100
56	22	29	35	41	45	51	56	59	60	61	62	63	64	67	100	100	100	100	100	100
57	22	29	35	41	45	50	54	56	58	59	61	62	63	100	100	100	100	100	100	100
58	22	30	36	41	44	49	53	56	57	57	61	62	100	100	100	100	100	100	100	100
59	22	30	36	41	44	48	51	53	55	56	59	100	100	100	100	100	100	100	100	100
60	22	30	36	41	43	47	50	51	53	55	100	100	100	100	100	100	100	100	100	100
61	22	29	35	39	42	46	49	50	52	80	100	100	100	100	100	100	100	100	100	100
62	20	28	33	39	41	45	47	49	80	80	100	100	100	100	100	100	100	100	100	100
63	20	28	33	38	41	44	46	80	80	80	100	100	100	100	100	100	100	100	100	100
64	19	27	32	36	40	42	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	19	25	30	35	39	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	19	25	30	35	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	19	25	30	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	19	25	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	19	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(5) The select mortality factors for female nonsmoker are as shown in the table below:

Female Nonsmoker - Select Mortality Factors																				
Duration																				
Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Age																				
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	96	98	98	98	98	99	99	99	92	92	93	95	95	97	99	99	99	100	100	100
18	78	80	80	80	80	81	81	74	75	75	78	79	82	83	85	88	91	94	97	100
19	60	62	63	63	63	65	59	59	60	60	64	67	67	70	72	78	83	89	94	100
20	42	44	45	45	45	42	42	42	45	45	50	51	53	56	58	66	75	83	92	100
21	41	42	44	45	41	42	42	44	47	47	51	53	54	57	59	67	75	84	92	100
22	39	41	44	41	41	42	44	45	49	49	54	56	57	58	60	68	76	84	92	100
23	38	41	38	40	41	42	44	46	49	50	56	57	58	60	62	70	77	85	92	100
24	36	36	38	40	41	42	46	47	50	51	58	59	60	62	63	70	78	85	93	100
25	32	34	37	40	41	43	46	49	51	53	59	60	62	63	64	71	78	86	93	100
26	32	34	37	41	43	45	47	50	53	53	60	62	63	64	62	70	77	85	92	100
27	32	34	38	43	46	47	49	51	53	55	62	63	64	62	62	70	77	85	92	100
28	30	34	39	43	47	49	51	53	56	58	63	63	61	62	63	70	78	85	93	100
29	30	35	40	45	50	51	52	55	58	59	64	61	62	63	63	70	78	85	93	100
30	31	35	40	46	51	52	53	56	59	60	62	62	63	65	65	72	79	86	93	100
31	31	35	40	46	51	53	55	58	60	58	62	62	63	65	65	72	79	86	93	100
32	32	35	40	45	51	53	56	59	57	58	62	63	63	65	64	71	78	86	93	100
33	32	36	41	47	52	55	58	55	58	59	63	63	65	65	65	72	79	86	93	100
34	33	36	41	47	52	55	55	57	58	59	63	65	64	65	64	71	78	86	93	100
35	33	36	41	47	52	53	57	58	59	61	63	64	64	64	64	71	78	86	93	100
36	33	36	41	47	49	53	57	58	59	61	63	64	63	64	63	70	78	85	93	100
37	32	36	41	44	49	53	57	58	59	60	62	62	61	62	63	70	78	85	93	100
38	32	37	39	45	50	54	57	58	60	60	61	61	61	62	61	69	77	84	92	100
39	30	35	39	45	50	54	57	58	60	59	60	60	59	60	61	69	77	84	92	100
40	28	35	39	45	50	54	56	57	59	59	60	59	59	59	60	68	76	84	92	100
41	28	35	39	45	49	52	55	55	58	57	58	59	58	59	60	68	76	84	92	100
42	27	35	39	44	49	52	54	55	56	57	57	57	58	60	61	69	77	84	92	100
43	27	34	39	44	47	50	53	53	55	55	56	57	56	60	61	69	77	84	92	100
44	26	34	38	42	47	50	52	53	54	55	55	55	56	61	62	70	77	85	92	100
45	26	33	38	42	45	48	51	51	52	53	54	55	56	61	62	70	77	85	92	100

Approved Insurance Tables

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Female Nonsmoker - Select Mortality Factors																				
Issue		Duration																		
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
46	24	32	37	40	43	47	49	51	52	53	54	55	56	60	61	69	77	84	92	100
47	24	30	35	39	42	45	47	49	51	53	54	55	56	59	60	68	76	84	92	100
48	23	30	35	37	40	44	47	49	50	53	54	55	55	59	57	66	74	83	91	100
49	23	29	33	35	39	42	45	48	50	53	54	55	55	57	56	65	74	82	91	100
50	21	27	32	34	37	41	44	48	50	53	54	55	55	56	55	64	73	82	91	100
51	21	26	30	34	37	41	44	48	49	51	53	53	54	55	55	64	73	82	91	100
52	20	25	30	33	37	41	44	47	48	50	50	51	51	55	53	62	72	81	100	100
53	19	24	29	32	37	41	43	47	48	48	49	49	51	52	52	62	71	100	100	100
54	18	24	29	32	37	41	43	45	47	47	47	49	49	51	51	61	100	100	100	100
55	18	23	28	32	37	41	43	45	45	45	46	46	47	50	50	100	100	100	100	100
56	18	23	28	32	36	39	42	44	44	45	46	46	46	49	100	100	100	100	100	100
57	18	23	28	31	35	38	41	42	44	44	45	45	46	100	100	100	100	100	100	100
58	17	23	26	31	35	36	38	41	41	42	45	45	100	100	100	100	100	100	100	100
59	17	23	26	30	33	35	38	39	40	41	44	100	100	100	100	100	100	100	100	100
60	17	23	26	30	32	34	36	38	39	40	100	100	100	100	100	100	100	100	100	100
61	17	22	25	29	32	33	35	36	38	80	100	100	100	100	100	100	100	100	100	100
62	16	22	25	28	30	32	34	35	80	80	100	100	100	100	100	100	100	100	100	100
63	16	20	24	28	30	32	34	80	80	80	100	100	100	100	100	100	100	100	100	100
64	14	21	24	27	29	30	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	15	19	23	25	28	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	15	19	23	25	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	15	19	22	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	13	18	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	13	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

(6) The select mortality factors for female smoker are as shown in the table below:

Female Smoker - Select Mortality Factors																				
Issue		Duration																		
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
0-15	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
16	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
17	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
18	99	100	100	100	100	100	100	95	96	97	100	100	100	100	100	100	100	100	100	100
19	87	89	92	92	92	92	84	84	86	86	92	93	95	96	99	99	99	100	100	100
20	74	77	80	80	80	73	73	73	75	77	83	83	86	88	90	92	94	96	98	100
21	71	74	78	78	71	71	73	74	77	79	85	86	88	89	90	92	94	96	98	100
22	68	71	75	70	71	71	73	74	78	79	88	90	89	89	92	94	95	97	98	100
23	65	69	67	70	70	70	73	77	79	81	89	90	90	92	92	94	95	97	98	100
24	62	60	64	69	70	70	74	77	79	81	92	90	92	93	93	94	96	97	99	100
25	53	58	63	67	69	70	74	78	81	82	92	93	93	95	95	96	97	98	99	100
26	53	58	63	69	71	72	75	79	82	82	93	93	95	96	90	92	94	96	98	100
27	52	56	63	70	74	74	78	81	82	84	93	95	95	90	90	92	94	96	98	100
28	52	56	64	71	75	77	79	82	85	86	95	95	90	92	92	94	95	97	98	100
29	51	56	64	71	78	78	81	84	86	88	95	90	90	92	92	94	95	97	98	100
30	51	56	64	72	79	79	82	85	88	89	90	90	92	93	93	94	96	97	99	100
31	51	56	64	72	78	81	84	84	88	84	90	90	92	93	93	94	96	97	99	100
32	51	56	64	71	78	81	85	86	84	85	90	90	92	94	93	94	96	97	99	100
33	51	57	62	71	78	82	85	83	84	85	90	92	93	93	93	94	96	97	99	100
34	51	56	62	71	78	82	81	83	85	86	90	92	92	94	93	94	96	97	99	100
35	51	56	62	71	78	79	83	84	85	86	90	91	91	93	93	94	96	97	99	100
36	49	56	62	71	74	79	83	84	85	86	90	90	91	93	92	94	95	97	98	100
37	48	55	62	67	74	79	83	84	85	86	89	90	89	92	91	93	95	96	98	100
38	47	55	57	66	72	77	81	84	86	86	87	88	88	90	91	93	95	96	98	100
39	45	50	57	66	72	77	81	83	85	86	86	87	86	89	90	92	94	96	98	100
40	41	50	57	66	72	77	81	83	84	85	86	86	86	89	89	91	93	96	98	100
41	40	50	57	65	71	76	79	81	83	84	85	86	85	89	90	92	94	96	98	100

Issue	Female Smoker - Select Mortality Factors																			
	Duration																			
Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
42	40	49	57	65	69	74	77	80	82	83	84	85	86	90	92	94	95	97	98	100
43	39	49	55	63	69	73	76	78	80	82	83	84	85	92	93	94	96	97	99	100
44	39	48	55	62	67	71	75	78	80	80	82	84	86	93	96	97	98	98	99	100
45	37	47	55	61	65	70	73	76	78	80	81	84	86	94	97	98	98	99	99	100
46	36	46	53	59	63	68	71	75	77	79	83	85	86	93	96	97	98	98	99	100
47	34	44	51	57	62	66	70	75	77	80	83	85	86	93	94	95	96	98	99	100
48	34	44	50	54	60	64	69	74	77	80	84	86	87	92	92	94	95	97	98	100
49	33	42	48	53	58	63	68	74	77	81	84	86	87	92	91	93	95	96	98	100
50	31	41	46	51	57	61	67	74	77	81	85	87	87	91	90	92	94	96	98	100
51	30	39	45	51	56	61	67	74	75	80	83	85	85	90	90	92	94	96	98	100
52	29	38	45	50	56	62	68	74	75	79	81	83	84	90	90	92	94	96	100	100
53	28	37	43	49	57	62	68	73	74	77	79	81	83	89	89	91	93	100	100	100
54	28	36	43	49	57	63	69	73	74	75	78	80	81	87	89	91	100	100	100	100
55	26	35	42	49	57	63	69	73	73	74	76	78	79	86	87	100	100	100	100	100
56	26	35	42	49	56	62	67	71	72	74	76	78	79	85	100	100	100	100	100	100
57	26	35	42	49	55	61	66	69	72	73	76	78	79	100	100	100	100	100	100	100
58	28	36	43	49	55	59	63	68	69	72	76	78	100	100	100	100	100	100	100	100
59	28	36	43	49	54	57	63	67	68	70	76	100	100	100	100	100	100	100	100	100
60	28	36	43	49	53	57	61	64	67	69	100	100	100	100	100	100	100	100	100	100
61	26	35	42	48	52	56	59	63	66	80	100	100	100	100	100	100	100	100	100	100
62	26	33	41	47	51	55	58	62	80	80	100	100	100	100	100	100	100	100	100	100
63	25	33	41	46	51	55	57	80	80	80	100	100	100	100	100	100	100	100	100	100
64	25	33	40	45	50	53	80	80	80	80	100	100	100	100	100	100	100	100	100	100
65	24	32	39	44	49	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
66	24	32	39	44	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
67	24	32	39	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
68	24	32	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
69	24	64	68	72	72	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
70	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
71	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
72	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
73	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
74	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
75	60	60	64	68	68	72	75	75	80	80	100	100	100	100	100	100	100	100	100	100
76	60	60	64	68	68	72	75	75	80	100	100	100	100	100	100	100	100	100	100	100
77	60	60	64	68	68	72	75	75	100	100	100	100	100	100	100	100	100	100	100	100
78	60	60	64	68	68	72	75	100	100	100	100	100	100	100	100	100	100	100	100	100
79	60	60	64	68	68	72	100	100	100	100	100	100	100	100	100	100	100	100	100	100
80	60	60	64	68	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
81	60	60	64	68	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
82	60	60	64	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
83	60	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
84	60	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
85+	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

[Statutory Authority: RCW 48.02.060, 48.74.030, 48.74.040, 48.74.070, and 48.74.080. 00-07-069, § 284-74-380, filed 3/13/00, effective 4/13/00.]

WAC 284-74-400 Purpose. The purpose of this regulation, WAC 284-74-400 through 284-74-460, is to recognize and prescribe the use of the 2001 commissioners standard ordinary (CSO) mortality table in compliance with RCW 48.74.030 (1)(a)(iii), 48.76.050 (4)(h)(vi), and WAC 284-74-340 (1) and (2).

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-400, filed 2/2/04, effective 3/4/04.]

WAC 284-74-410 Definitions. (1) "2001 CSO mortality table" means that mortality table, consisting of separate rates of mortality for male and female lives, adopted by the National Association of Insurance Commissioners (NAIC) in December of 2002. The 2001 CSO mortality table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO mortality table" includes both the ultimate form and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality

tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

(2) "2001 CSO mortality table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO mortality table.

(3) "2001 CSO mortality table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO mortality table.

(4) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(5) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-410, filed 2/2/04, effective 3/4/04.]

WAC 284-74-420 2001 CSO mortality table. (1) The 2001 commissioners standard ordinary (CSO) mortality table may be used as allowed in RCW 48.74.030 (1)(a)(iii), 48.76.-

050 (4)(h)(vi), and WAC 284-74-340 (1) and (2), subject to the conditions in this regulation.

(2) An insurer may elect to use the 2001 CSO mortality table as the minimum standard for policies issued on or after January 1, 2004, until January 1, 2009. This table may be used for any one or more specified plans of insurance subject to the conditions in this regulation. If the insurer elects to use the 2001 CSO mortality table, it must do so for both valuation and nonforfeiture purposes.

(3) An insurer must use the 2001 CSO mortality table as the minimum standard for policies issued on or after January 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-420, filed 2/2/04, effective 3/4/04.]

WAC 284-74-430 Conditions. (1) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(a) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(b) 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) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(2) The composite mortality tables must be used for plans of insurance without separate rates for smokers and nonsmokers.

(3) The insurer for each plan of insurance may use the 2001 CSO mortality table in its ultimate or select and ultimate form to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits. This is subject to the restrictions of WAC 284-74-440 and 284-74-300 through 284-74-380 regarding the use of the select and ultimate form.

(4) When the 2001 CSO mortality table is the minimum reserve standard for any plan for an insurer, the actuarial opinion in the annual statement filed with the commissioner must be based on an asset adequacy analysis as specified in WAC 284-07-380. The commissioner may exempt an insurer from this requirement if it only does business in Washington.

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-430, filed 2/2/04, effective 3/4/04.]

WAC 284-74-440 Applicability to WAC 284-74-300 through 284-74-380. (1) The 2001 CSO mortality table may be used in applying WAC 284-74-300 through 284-74-380 in the following manner, subject to the transition dates for use of the 2001 CSO mortality table in WAC 284-74-420 of this regulation (unless otherwise noted, the references in this section are to WAC 284-74-300 through 284-74-380):

(a) WAC 284-74-320 (1)(b)(ii): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO mortality table.

(b) WAC 284-74-330(2): All calculations are made using the 2001 CSO mortality rate, and, if elected, the

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optional minimum mortality standard for deficiency reserves stipulated in (d) of this subsection. The value of " q_{x+k+t} " is the valuation mortality rate for deficiency reserves in policy year $k+t$, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(c) WAC 284-74-340(1): The 2001 CSO mortality table is the minimum standard for basic reserves.

(d) WAC 284-74-340(2): The 2001 CSO mortality table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in WAC 284-74-340 (3)(a) through (i). In demonstrating compliance with those conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO mortality table with those tests that utilize the 2001 CSO mortality table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant actuarial standards of practice.

(e) WAC 284-74-350(3): The valuation mortality table used in determining the tabular cost of insurance is the ultimate mortality rates in the 2001 CSO mortality table.

(f) WAC 284-74-350 (5)(e): The calculations specified in WAC 284-74-350(5) must use the ultimate mortality rates in the 2001 CSO mortality table.

(g) WAC 284-74-350 (6)(e): The calculations specified in WAC 284-74-350(6) must use the ultimate mortality rates in the 2001 CSO mortality table.

(h) WAC 284-74-350 (7)(b): The calculations specified in WAC 284-74-350(7) must use the ultimate mortality rates in the 2001 CSO mortality table.

(i) WAC 284-74-360 (1)(a)(ii): The one-year valuation premium must be calculated using the ultimate mortality rates in the 2001 CSO mortality table.

(2) Nothing in this section expands the applicability of WAC 284-74-300 through 284-74-380 to include life insurance policies exempted under WAC 284-74-320(1).

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-440, filed 2/2/04, effective 3/4/04.]

WAC 284-74-450 Gender blended tables. (1) On or after January 1, 2004, an insurer may substitute a blended mortality table for the 2001 CSO mortality table for any ordinary life insurance policy delivered or issued for delivery in this state. The ordinary life policy must have (a) utilized the same premium rates and charges for male and female lives and (b) been issued in circumstances where applicable law does not permit distinctions on the basis of gender. The substituted table may blend the 2001 CSO mortality table (M) and the 2001 CSO mortality table (F) for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. The table may be used for any one or more specified plans of insurance subject to the conditions in this regulation. No change in minimum valuation standards is implied by this subsection.

(2) The insurer may choose from among the blended tables developed by the American Academy of Actuaries CSO task force and adopted by the NAIC in December of 2002. The mortality table chosen must be based on the blend of lives by gender expected for the policies to be issued. The 2001 CSO mortality table (M) and 2001 CSO mortality table

(F) may only be used where the proportion of individuals insured is anticipated to be ninety percent or more of one gender or the other.

(3) An insurer shall not use gender blended mortality tables unless:

(a) The Norris decision (Arizona Governing Committee v. Norris, 463 U.S. 1073, 103 S. Ct. 3492, 77 1. Ed 2d 1236 (1983)) or other federal law is known to apply to the policies involved; or

(b) The insurer has a bona fide concern that the Norris decision or other federal law might reasonably be construed to apply by a court having jurisdiction.

(4) It is not a violation of RCW 48.30.300 for an insurer to issue the same kind of policy of life insurance on both a gender distinct and gender neutral basis.

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-450, filed 2/2/04, effective 3/4/04.]

WAC 284-74-460 Effective date. The effective date of this regulation is January 1, 2004.

[Statutory Authority: RCW 48.02.060, 48.74.030, and 48.76.050. 04-04-070 (Matter No. R 2003-02), § 284-74-460, filed 2/2/04, effective 3/4/04.]

Chapter 284-78 WAC

JOINT UNDERWRITING ASSOCIATION FOR DAY CARE INSURANCE

WAC

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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

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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,

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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.

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(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.

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[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 284-83 WAC

LONG-TERM CARE INSURANCE RULES

WAC

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 284-83-225 Separation of data regarding certain policies.
 284-83-230 Loss ratio requirements for long-term care insurance forms.
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 284-83-300 Standards for protecting patient privacy rights.
 284-83-310 Right of insureds to receive confidential health services.
 284-83-320 Standards for the issuer's timely review of a claim denial.

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Standard applied if there is a conflict between a master policy and certificate of insurance.

WAC 284-83-005 Applicability and scope. (1) Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies delivered or issued for delivery in this state on or after January 1, 2009, including qualified long-term care policies and life insurance policies that accelerate benefits for long-term care. This chapter applies to insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations and all similar entities (collectively called "issuers" in this chapter).

(2) Some sections of this chapter apply only to qualified long-term care insurance policies, as provided for by the Health Insurance Portability and Accountability Act of 1996 and by Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(3) This chapter applies to policies delivered or issued for delivery in this state having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy commence after the policyholder has reached Social Security's normal retirement age, unless the benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a), 08-24-019 (Matter No. R 2008-09), § 284-83-005, filed 11/24/08, effective 12/25/08.]

WAC 284-83-010 Definitions and standards. For the purpose of this chapter, the following definitions and standards apply, unless the context clearly requires otherwise.

(1) "Certificate" has the meaning set forth in RCW 48.83.020(2).

(2) "Exceptional increase" means only those increases filed by the issuer as exceptional for which the commissioner determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state; or due to increased and unexpected utilization that affects the majority of issuers of similar products. Except as provided in WAC 284-83-090, exceptional increases are subject to the same requirements as other premium rate schedule increases. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, must also determine any potential offsets to higher claims costs.

(3) "Incidental," as used in WAC 284-83-090, means a value of the long-term care benefits provided that is less than ten percent of the total value of the benefits provided over the life of the policy. These values must be measured as of the date of issue. In simple cases where the base policy and the long-term care benefits have separately identifiable premi-

ums, the premiums can be directly compared. In other cases, annual cost of insurance charges might be available for comparison. Some cases may involve comparison of present value of benefits.

(4) "Group long-term care insurance" has the meaning set forth in RCW 48.83.020(6).

(5) "Guaranteed renewable" means that renewal of a long-term care insurance policy cannot be declined by the issuer for any reason except nonpayment of premiums, but the issuer can revise rates on a class basis.

(6) "Insured" means any beneficiary or owner of a long-term care policy regardless of the type of issuer.

(7) "Issuer" has the meaning set forth in RCW 48.83.020(4).

(8) "Noncancellable" means that renewal of a long-term care insurance policy cannot be declined and rates cannot be revised by the issuer.

(9) "Policy" has the meaning set forth in RCW 48.83.020(7), unless the context clearly indicates otherwise, and includes certificates issued under a group policy.

(10) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(11) "Qualified long-term care insurance" has the meaning set forth in RCW 48.83.020(8).

(12) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by the issuer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in RCW 48.83.020 (6)(a) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: Institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-010, filed 11/24/08, effective 12/25/08.]

WAC 284-83-015 Standards for policy definitions and terms. A long-term care insurance policy or certificate delivered or issued for delivery in this state must not use the following terms unless the terms are defined in the policy or certificate and the definitions satisfy the following standards. This section specifies minimum standards for several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

(1) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(2) "Acute condition" means that the individual is medically unstable. An individual with an acute condition requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Adult day care" or "adult day health care" means a program of social or 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 home.

(4) "Bathing" means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(5) "Cognitive impairment" means a deficiency in a person's short or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(6) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(7) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(8) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(9) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(10) "Home health care services" means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include home-maker services, assistance with activities of daily living and respite care services.

(11) "Managed-care plan" or "plan of care" means a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(12) "Medicare" means "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.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Skilled nursing care," "personal care," "home care," "specialized care," "assisted living care" and other services must be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(15) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(16) "Transferring" means moving into or out of a bed, chair or wheelchair.

(17) "Skilled nursing facility," "nursing facility," "extended care facility," "convalescent nursing home," "personal care facility," "specialized care providers," "assisted living facility," "home care agency" and terms used to identify other providers of services must be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it must also state what requirements a provider must meet in lieu of licensure, certification or registration if

the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or if the state licenses, certifies or registers the provider of services under another name.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-015, filed 11/24/08, effective 12/25/08.]

WAC 284-83-020 Standards for policy provisions.

The following standards for policy provisions apply to all long-term care insurance policies delivered or issued for delivery in this state.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" must not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements of WAC 284-83-035.

(a) A policy or certificate issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, if the issuer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and the issuer cannot decline to renew, except that rates may be revised by the issuer on a class basis.

(c) The term "noncancellable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance and has no right to unilaterally make any change in the premium rate.

(d) The term "level premium" may be used only if the issuer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection, a qualified long-term care insurance policy or certificate must be guaranteed renewable, within the meaning of Section 7702B (b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and exclusions. A long-term care policy or certificate shall not be delivered or issued for delivery in this state as long-term care insurance if it limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following permitted exclusions:

(a) Preexisting conditions or diseases;

(b) Alcoholism and drug addiction;

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

(i) War (whether declared or undeclared);

(ii) Participation in a felony, riot or insurrection;

(iii) Service in the armed forces or units auxiliary thereto;

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

(v) Aviation (this exclusion applies only to nonfare-paying passengers);

(d) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensa-

tion, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(f) In the case of a qualified long-term care insurance policy only, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount;

(g) Issuers may not prohibit, exclude or limit services based on type of provider or limit a coverage if services are provided in a state other than the state where the policy was originally issued, except:

(i) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, unless the provider satisfies the policy requirements outlined for providers in lieu of licensure certificate or registration; or

(ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(iii) Issuers may exclude or limit payment for services provided outside the United States or permit or limit benefit levels to reflect legitimate variations or differences in provider rates, but issuers must cover services that would be covered in the state of issue irrespective of any licensing, registration or certification requirements for providers in the other state. In other words, if the claim would be approved but for the licensing issue, the claim must be approved for payment.

(3) Extension of benefits. Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The 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 policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or conversion. Group long-term care insurance issued in this state on or after January 1, 2009, must provide covered individuals with a basis for continuation or conversion of coverage.

(a) For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(i) Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy.

(ii) The commissioner will make a determination as to the substantial equivalency of benefits, and in doing so, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(b) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, is entitled to the issuance of a converted policy by the issuer under whose group policy he or she is covered, without evidence of insurability.

(c) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities the commissioner, in making a determination as to the substantial equivalency of benefits, will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

(d) Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the issuer not later than thirty-one days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and must be renewable annually.

(e) Except where the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(f) Continuation of coverage or issuance of a converted policy is mandatory, except where:

(i) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) The terminating coverage is replaced not later than thirty-one days after termination by group coverage effective on the day following the termination of coverage and the replacement coverage provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and the premium is calculated in a manner consistent with the requirements of (e) of this subsection.

(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by

the converted policy, would result in payment of more than one hundred percent of incurred expenses. The provision may only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(h) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, do not exceed those that would have been payable had the individual's coverage under the group policy remained in full force and effect.

(i) Notwithstanding any other provision of this section, the insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person must be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer must offer coverage to all insured persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the issuer and premiums charged to persons under the new group policy:

(a) Must not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(b) Must not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(6)(a) The premium charged to the insured must not increase due to either the increasing age of the insured at ages beyond sixty-five or the duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase; but for purposes of the calculation required under WAC 284-83-090, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change; but for purposes of the calculation required under WAC 284-83-090, the initial annual premium must be based on the reduced benefits.

(7) Electronic enrollment for group policies.

(a) In the case of a group, as defined in RCW 48.83.020 (6)(a), any requirement that a signature of the insured be obtained by an insurance producer or issuer will be deemed satisfied only if:

(i) The consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer and verification of enrollment information is provided to the insured;

(ii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(iii) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

(b) Upon request of the commissioner, the issuer must make available records that demonstrate the issuer's ability to confirm enrollment and coverage amounts.

(8) Each long-term care policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "long-term care insurance" policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-020, filed 11/24/08, effective 12/25/08.]

WAC 284-83-025 Unintentional lapse. As a protection against unintentional lapse, each issuer offering long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate may be issued until the issuer has received from the applicant either a written designation of at least one person in addition to the applicant who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(i) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.

(ii) Designation does not constitute acceptance of any liability on the third party for services provided to the insured.

(iii) The form used for the written designation must provide space clearly designated for listing at least one person.

(iv) The designation must include each person's full name and home address.

(v) If the applicant elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(vi) No less frequently than once every two years the issuer must notify the insured of the right to change this written designation.

(b) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (a) of this subsection need not be met until sixty days after the policyholder or certificateholder is no longer on the payment plan. The application or enrollment form for such policies or certificates must clearly show the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the issuer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to (a) of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice must be given by first class United States mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date of mailing.

(2) Reinstatement. In addition to the requirements in subsection (1) of this section, a long-term care insurance pol-

icy or certificate must include a provision that provides for reinstatement of coverage in the event of lapse if the issuer is provided proof that the policyholder or certificateholder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired.

(a) Reinstatement must be available to the insured if requested within five months after lapse and may allow for the collection of past due premium, where appropriate.

(b) The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-025, filed 11/24/08, effective 12/25/08.]

WAC 284-83-030 Required disclosure provisions. (1) Renewability. Long-term care insurance policies must contain a renewability provision.

(a) The renewability provision must be appropriately captioned, must appear on the first page of the policy, and must clearly state that the coverage is guaranteed renewable or noncancellable. This provision does not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder, such as long-term care policies which are part of or combined with life insurance policies because life insurance policies generally do not contain renewability provisions.

(b) A long-term care insurance policy or certificate, other than one where the issuer does not have the right to change the premium, must include a statement that premium rates may change.

(2) Riders and endorsements.

(a) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after the date of issue, or at reinstatement or renewal, that reduce or eliminate benefits or coverage in the policy must require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in a writing signed by the insured, except when the increase in benefits or coverage is required by law.

(c) If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy, rider or endorsement.

(3) Payment of benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, must include a definition and explanation of the terms in its accompanying outline of coverage, as set forth in WAC 284-83-145.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy or certificate and must be labeled as "pre-existing condition limitations."

(5) Other limitations or conditions on eligibility for benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited under chapter 48.83 RCW, must set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and must label that paragraph "limitations or conditions on eligibility for benefits."

(6) Disclosure of tax consequences. At the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted, a life insurance policy or certificate that provides an accelerated benefit for long-term care must disclose that receipt of the accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor. The disclosure statement must be prominently displayed on the first page of the policy, certificate or rider and any other related documents. This subsection does not apply to qualified long-term care insurance policies.

(7) Benefit triggers. Activities of daily living and cognitive impairment shall be used to measure the insured's need for long-term care and must be described in the policy or certificate in a separate paragraph labeled "eligibility for the payment of benefits." Any additional benefit triggers must be explained in the same section.

(a) If benefit triggers differ for different benefits, a clear explanation of the benefit trigger must accompany each benefit description.

(b) If an attending physician or other specified person is required to certify a certain level of functional dependency in order for the insured to be eligible for benefits, this must be specified.

(8) A qualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC 284-83-145, that the policy is intended to be a qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance policy must include a disclosure statement in the policy and in the outline of coverage, as set forth in WAC 284-83-145, that the policy is not intended to be a qualified long-term care insurance policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-030, filed 11/24/08, effective 12/25/08.]

WAC 284-83-035 Required disclosure of rating practices to consumers. (1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued for delivery in this state on or after January 1, 2009.

(b) Certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a), that were in force prior to January 1, 2009, the provisions of this section apply on the policy anniversary first following January 1, 2009.

(2) Except for policies for which no applicable premium rate or rate schedule increases can be made, the issuer must provide all of the information listed in this subsection to the applicant at the time of application or enrollment. If the

method of application does not allow for delivery at that time, the issuer must provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate. For example, a method of delivery that does not allow for all listed information to be provided at time of application or enrollment is an application by mail.

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule including:

(i) A description of when premium rate or rate schedule adjustments will be effective (for example, next anniversary date or next billing date); and

(ii) The right to a revised premium rate or rate schedule as provided for in (c) of this subsection if the premium rate or rate schedule is changed;

(e)(i) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(A) The policy forms for which premium rates have been increased;

(B) The calendar years when the form was available for purchase; and

(C) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(ii) The issuer, in a fair manner, may provide additional explanatory information related to the rate increases.

(iii) The issuer may exclude from the disclosure, premium rate increases that only apply to blocks of business acquired from other nonaffiliated issuers or the long-term care policies acquired from other nonaffiliated issuers when those increases occurred prior to the acquisition.

(iv) If the acquiring issuer files for a rate increase on a long-term care policy form acquired from a nonaffiliated issuer or a block of policy forms acquired from a nonaffiliated issuer on or before the later of January 1, 2009, or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring issuer may exclude that rate increase from the disclosure; however, the nonaffiliated selling issuer must include the disclosure of that rate increase in accordance with (e)(i) of this subsection.

(v) If the acquiring issuer in (e)(iv) of this subsection files for a subsequent rate increase at any time (including during the twenty-four-month period following the acquisition of the block or policies) on the same policy form acquired from a nonaffiliated issuer or block of policy forms acquired from a nonaffiliated issuer referenced in (e)(iv) of this subsection, the acquiring issuer must make all disclosures required by (e) of this subsection, including disclosure of the earlier rate increase.

(vi) If the policy is for employer-group coverage, the disclosures in this subsection need to be made only to the employer if the employer is paying the entire premium and no contributions or coverage elections are made by individual employees.

(3) The applicant must sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the issuer made the disclosure required under subsection (2)(a) and (e) of this section. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.

(4) The forms provided in WAC 284-83-170 and 284-83-190 must be used by the issuer to comply with the requirements of subsections (2) and (3) of this section.

(5) The issuer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, as applicable, at least forty-five days prior to the implementation of any premium rate schedule increase by the issuer. The notice must include the information required by subsection (2) of this section when the rate increase is implemented.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-035, filed 11/24/08, effective 12/25/08.]

WAC 284-83-040 Initial rate filing requirements.

The issuer must provide the following information to the commissioner no fewer than thirty days prior to making a long-term care insurance form available for sale in this state:

(1) A copy of each disclosure document required in WAC 284-83-035; and

(2) An actuarial certification consisting of at least the following:

(a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(d) A complete description of the basis for policy reserves that are anticipated to be held under the form, including:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating, where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where this does not occur;

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(A) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(B) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration based on a standard age distribution; and

(e)(i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the issuer except for reasonable differences attributable to benefits; or

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the issuer with an explanation of the differences.

(3)(a) The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration must include:

(i) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences;

(ii) Relevant and credible data from other studies; or

(iii) Both (a)(i) and (ii) of this subsection.

(b) In the event the commissioner asks for additional information, the period in subsection (2) of this section does not include the period during which the issuer is preparing the requested information.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-040, filed 11/24/08, effective 12/25/08.]

WAC 284-83-045 Prohibition against post-claims underwriting.

(1) All applications for long-term care insurance policies or certificates except those that are guaranteed issue must contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application for long-term care insurance includes a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the prescribed medications.

(b) If the medications listed in the application were known by the issuer, or should have been known by the issuer at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate cannot be rescinded based on that condition.

(3) Except for policies or certificates which are guaranteed issue:

(a) The following language must be set out conspicuously and in close conjunction with the applicant's signature block on the application for a long-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, must be set out conspicuously on every long-term care insurance policy or certificate at the time of delivery:

"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon

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your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [Insert address]"

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the issuer must obtain one of the following:

- (i) A report of a physical examination;
- (ii) An assessment of functional capacity;
- (iii) An attending physician's statement; or
- (iv) Copies of the applicant's medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) must be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every issuer or other entity selling or issuing long-term care insurance benefits must maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily requested, and must annually furnish this information to the commissioner. The format is prescribed by the National Association Of Insurance Commissioners, and is set forth in WAC 284-83-165.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-045, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-050 Minimum standards for home health and community care benefits in long-term care insurance policies. (1) If a long-term care insurance policy or certificate provides benefits for home health care or community care services, it must not limit or exclude benefits:

(a) By requiring that the insured or claimant would need care in a nursing facility if home health care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered under the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before home health 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) If a long-term care insurance policy or certificate provides for home health or community care services, it must provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement does not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

(a) This permits the home health care benefits to be counted toward the maximum length of long-term care coverage under the policy.

(b) Home health care benefits must not be restricted to a period of time which would make the benefit illusory. For example, fewer than three hundred sixty-five benefit days and less than a twenty-five dollar daily maximum benefit are considered illusory home health care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-050, filed 11/24/08, effective 12/25/08.]

WAC 284-83-055 Requirement to offer inflation protection. (1) No issuer may offer a long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy 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 policy. Issuers must offer to each policyholder, at the time of purchase, the option to purchase a policy 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 of 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 must 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.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) of this section must be made to the group policyholder; however, if the policy is issued to a group defined in RCW 48.83.020 (6)(d), other than to a continuing care retirement community, the offering must be made to each proposed certificateholder.

(3) The offer in subsection (1) of this section is not required of life insurance policies or riders containing accelerated long-term care benefits.

(4)(a) Issuers must include the following information in or with the outline of coverage:

(i) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison must show benefit levels over at least a twenty-year period; and

(ii) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b) The issuer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure. For example, meaningful benefit minimums or durations could be demonstrated by showing increases to attained age, for a period such as at least twenty years, for some multiple of the policy's maximum benefit, or throughout the period of coverage.

(5) Inflation protection benefit increases under a policy that includes these benefits must continue without regard to the insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases must include an offer of a premium which the issuer expects to remain constant. Unless the premium is guaranteed to remain constant, the offer must disclose in a conspicuous manner that the premium may change in the future.

(7)(a) Inflation protection as provided in subsection (1)(a) of this section must be included in any long-term care insurance policy unless the issuer obtains a rejection of inflation protection signed by the policyholder. The rejection may be either part of the application or on a separate form.

(b) The rejection is considered a part of the application.

(c) The following language, or language substantially similar to the following, must be set out conspicuously on the rejection:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-055, filed 11/24/08, effective 12/25/08.]

WAC 284-83-060 Requirements for application forms and replacement coverage.

(1) Application forms must include questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other health or long-term care policy or certificate presently in force.

(a) A supplementary application or other form, signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by RCW 48.83.020 (6)(a), the required questions may be modified only to the extent neces-

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sary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(b) The following questions, or words substantially similar to the following, must be used:

(i) "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?"

(ii) Did you have another long-term care insurance policy or certificate in force during the last twelve months? If so, with which company? If that policy lapsed, when did it lapse?

(iii) Are you covered by Medicaid?

(iv) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

(2) Insurance producers must list any other health insurance policies they have sold to the applicant that are still in force and any similar policies sold in the past five years that are no longer in force.

(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, the issuer, other than an issuer using direct response solicitation methods, or its insurance producer, must furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of health care or long-term care coverage. One copy of the notice must be retained by the applicant and an additional copy must be signed by the applicant and must be retained by the issuer. The notice set forth in WAC 284-83-063 must be used.

(4) Direct response solicitations. Issuers using direct response solicitation methods must deliver a notice regarding replacement of health or long-term care coverage to the applicant upon issuance of the policy. The required notice set forth in WAC 284-83-067 must be used.

(5) If replacement is intended, the replacing issuer must notify the existing issuer of the proposed replacement in writing. The existing policy must be identified by the issuer, including the name of the insured and policy number or address plus zip code. Notice must be made within five working days after the date the application is received by the issuer or the date the policy is issued, whichever is sooner.

(6) Life insurance policies that accelerate benefits for long-term care must comply with this section if the policy being replaced is a long-term care insurance policy.

(a) If the policy being replaced is a life insurance policy, the issuer must comply with the replacement requirements of WAC 284-23-400 through 284-23-485.

(b) If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing issuer must comply with both the long-term care and the life insurance replacement requirements.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-060, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-063 Notice to applicant regarding replacement of individual accident and sickness or long-term care insurance marketed by an insurance producer. The following notice is required in WAC 284-83-060(3):

[Title 284 WAC—p. 403]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL [ACCIDENT AND SICKNESS] [HEALTH] OR LONG-TERM CARE 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 lapse or otherwise terminate existing [accident and sickness] [health] or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] insurance company. Your new policy 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health] or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY [AGENT, BROKER, INSURANCE PRODUCER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- (1) Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of 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 or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its [agent] [insurance producer] 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.
- (4) 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 your sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of [Agent, Broker] [Insurance Producer] or Other Representative)

[Typed Name and Address of [Agent or Broker] [Insurance Producer]]

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

(Applicant's Signature)_____
(Date)

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-063, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-067 Notice to applicant regarding replacement of direct-marketed individual accident and sickness or long-term care insurance. The following notice is required by WAC 284-83-060(4):

NOTICE TO APPLICANT REGARDING REPLACEMENT OF [ACCIDENT AND SICKNESS] [HEALTH] OR LONG-TERM CARE 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 lapse or otherwise terminate existing [accident and sickness] [health] or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] insurance company. Your new policy 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.

You should review this new coverage carefully, comparing it with all [accident and sickness] [health] or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

- (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 in payment of 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 or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its [agent] [insurance producer] 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.
- (4) [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

[Company Name]

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-067, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-070 Reporting requirements. (1) Every issuer must maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Every issuer must report annually by June 30 the ten percent of its insurance producers with the highest percentages of lapses and replacements as measured by subsection (1) of this section on the form set forth in WAC 284-83-195.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely insurance producer activities regarding the sale of long-term care insurance.

(4) Every issuer must report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year on the form set forth in WAC 284-83-195.

(5) Every issuer must report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year on the form set forth in WAC 284-83-195.

(6) Every issuer must report annually by June 30, for qualified long-term care insurance policies, the number of

claims denied for each class of business, expressed as a percentage of claims denied on the form set forth in WAC 284-83-185.

(7) As used in this section:

(a) "Policy" refers only to long-term care insurance policies;

(b) "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means that the issuer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Reports required under this section must be filed with the commissioner.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-070, filed 11/24/08, effective 12/25/08.]

WAC 284-83-075 Discretionary powers of commissioner. Upon written request and after an administrative hearing, the commissioner may enter an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(1) The modification or suspension would be in the best interest of the insureds;

(2) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(3)(a) The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(b) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(c) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-075, filed 11/24/08, effective 12/25/08.]

WAC 284-83-080 Reserve standards. (1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits must be determined in accordance with RCW 48.74.030 (1)(g). Claim reserves must also be established in the case when the policy or rider is in claim status. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits; however, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, due regard must be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- (a) Definition of insured events;
- (b) Covered long-term care facilities;
- (c) Existence of home convalescence care coverage;
- (d) Definition of facilities;
- (e) Existence or absence of barriers to eligibility;
- (f) Premium waiver provision;
- (g) Renewability;
- (h) Ability to raise premiums;
- (i) Marketing method;
- (j) Underwriting procedures;
- (k) Claims adjustment procedures;
- (l) Waiting period;
- (m) Maximum benefit;
- (n) Availability of eligible facilities;
- (o) Margins in claim costs;
- (p) Optional nature of benefit;
- (q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

(2) If long-term care benefits are provided other than as provided in subsection (1) of this section, reserves must be determined in accordance with the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, unless otherwise provided by law, as required by RCW 48.05.073.

(3) Any applicable valuation morbidity table must be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-080, filed 11/24/08, effective 12/25/08.]

WAC 284-83-090 Premium rate schedule increases.

(1)(a) Except as provided in (b) of this subsection, this section applies to any long-term care policy or certificate issued in this state on or after January 1, 2009.

(b) For certificates issued on or after January 1, 2009, under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a), which policy was in force before January 1, 2009, the provisions of this section apply on the first policy anniversary following January 1, 2009.

(2) The issuer must provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to giving the notice to the policyholders and must include:

(a) Information required by WAC 284-83-035;

(b) Certification by a qualified actuary that:

(i) If the requested premium rate schedule increase is implemented and the underlying assumptions which reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

(ii) The premium rate filing is in compliance with the provisions of this section;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

(i) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date must be provided separately.

(B) The projections must include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase.

(C) The projections must demonstrate compliance with subsection (3) of this section.

(D) For exceptional increases:

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the commissioner determines that offsets may exist, the issuer must use appropriate net projected experience;

(ii) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(iii) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the issuer have been relied on by the actuary;

(iv) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(v) Composite rates reflecting projections of new certificates, if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(e) Sufficient information for review of the premium rate schedule increase by the commissioner.

(3) All premium rate schedule increases must be determined in accordance with the following requirements:

(a) Exceptional increases must provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases must be calculated so that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(i) The accumulated value of the initial earned premium times fifty-eight percent;

(ii) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(iii) The present value of future projected initial earned premiums times fifty-eight percent; and

(iv) Eighty-five percent of the present value of future projected premiums not in (b)(iii) of this subsection on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in (b)(ii) and (iv) of this subsection will also include seventy percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases must use the maximum valuation interest rate for policy reserves as specified in the accounting practices and procedures manuals adopted by the National Association Of Insurance Commissioners, except as otherwise provided by RCW 48.05.073. The actuary must disclose as part of the actuarial memorandum the use of any appropriate averages.

(4) For each rate increase that is implemented, the issuer must file for review by the commissioner updated projections, as defined in subsection (2)(c)(i) of this section, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions set forth in subsection (11) of this section, the projections

required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (2)(c)(i) of this section, must be filed for review by the commissioner every five years following the end of the required period in subsection (4) of this section. For group insurance policies that meet the conditions in subsection (11) of this section, the projections required by this subsection may be provided to the policyholder in lieu of filing with the commissioner.

(6)(a) If the commissioner determines that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (3) of this section, the commissioner may require the issuer to implement either premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (2)(c)(v) of this section, as applicable.

(c) For purposes of this section:

(i) The term "adequately match the projected experience" requires more than a comparison between actual and projected incurred claims. Other assumptions should be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product.

(ii) It is to be expected that the actual experience will not exactly match the issuer's projections. During the period that projections are monitored, the commissioner will determine whether there is an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the issuer must file:

(a) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form, requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection (8) of this section; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (8) of this section, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in subsection (3)(b)(i) and (iii) of this section.

(8)(a) For a rate increase filing that meets the following criteria for all policies included in the filing, the commissioner must review the projected lapse rates and past lapse

rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(i) The rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) The rate increase is not an exceptional increase; and

(iii) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) If significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the issuer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the issuer to offer all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the issuer or its affiliates without underwriting.

(i) The offer shall:

(A) Be subject to the approval of the commissioner;

(B) Be based on actuarially sound principles, but not be based on attained age; and

(C) Provide that maximum benefits under any new policy accepted by the insured must be reduced by comparable benefits already paid under the existing policy.

(ii) The issuer must maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase will be limited to the lesser of:

(A) The maximum rate increase determined based on the combined experience; and

(B) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

(9) If the commissioner determines that the issuer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, in addition to the provisions of subsection (8) of this section, the commissioner may prohibit the issuer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Subsections (1) through (9) of this section do not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in WAC 284-83-010, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements (as applicable) in any of the following:

(i) Chapter 48.76 RCW;

(ii) RCW 48.23.420 through 48.23.450; and

(iii) RCW 48.18A.050;

(c) The policy meets the disclosure requirements of RCW 48.83.070(2) and 48.83.080;

(d) The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable requirements in the following:

(i) Policy illustrations as required by chapter 48.23A RCW;

(ii) Disclosure requirements in WAC 284-23-300 through 284-23-370; and

(iii) Disclosure requirements in RCW 48.18A.030;

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Subsections (6) and (8) of this section do not apply to group insurance policies as defined in RCW 48.83.020 (6)(a), if:

(a) The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

(b) The policyholder, and not the certificateholder, pays a material portion of the premium, which must not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-090, filed 11/24/08, effective 12/25/08.]

WAC 284-83-095 Filing requirements. Prior to offering group long-term care insurance to a resident of this state pursuant to RCW 48.83.030, the issuer or similar organization must file with the commissioner evidence that the group policy or certificate has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those of this state.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-095, filed 11/24/08, effective 12/25/08.]

WAC 284-83-100 Filing requirements for advertising. (1) Every issuer or other entity issuing long-term care insurance in this state must provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium for review by the commissioner. In addition, a copy of all advertisements must be retained by the issuer for at least three years after the date the advertisement was first used.

(2) The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-100, filed 11/24/08, effective 12/25/08.]

WAC 284-83-105 Standards for marketing. (1) Every issuer or entity marketing long-term care insurance coverage in this state, directly or through its insurance producers, must:

(a) Establish marketing procedures and insurance producer training requirements to ensure that:

(i) Any marketing activities, including any comparison of policies, by its insurance producers, other representatives, or employees are fair and accurate; and

(ii) Excessive insurance is not sold or issued.

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following notice:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) Provide copies of the disclosure forms required in WAC 284-83-035(3), 284-83-170 and 284-83-190 to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has health or long-term care insurance and the types and amounts of any such insurance. For qualified long-term care insurance policies, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has health care coverage is not required.

(e) Every issuer or other entity marketing long-term care insurance must establish auditable procedures for verifying compliance with this subsection.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by its commissioner, at time of solicitation for long-term care insurance the issuer must provide written notice to the prospective policyholder and certificateholder that the counseling program is available and provide its name, address and telephone number.

(g) For long-term care insurance policies, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to WAC 284-83-020 (1)(c).

(2009 Ed.)

(h) Provide an explanation of contingent benefit upon lapse provided for in WAC 284-83-130 (4)(c) and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in WAC 284-83-130 (4)(d).

(2) In addition to the practices prohibited in chapters 48.30 RCW and 284-30 WAC, the following acts and practices are prohibited:

(a) Twisting, as defined in RCW 48.30.180.

(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 undue pressure to purchase 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 producer or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3)(a) With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in RCW 48.83.020 (6)(b), when endorsing or selling long-term care insurance must be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations must provide objective information regarding long-term care insurance policies or certificates endorsed or sold by the associations to ensure that members of the associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The issuer must file with the commissioner the following material:

(i) The policy and certificate;

(ii) A corresponding outline of coverage; and

(iii) All advertisements requested by the commissioner.

(c) The association must disclose in any long-term care insurance solicitation:

(i) The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(ii) A brief description of the process under which the policies and the issuer issuing the policies were selected.

(d) If the association and the issuer have interlocking directorates or trustee arrangements, the association must disclose that fact to its members.

(e) The board of directors of associations selling or endorsing long-term care insurance policies or certificates must review and approve the insurance policies as well as the compensation arrangements made with the issuer.

(f) The association must also:

(i) At the time of the association's decision to endorse the selling of long-term care insurance policies or certificates, engage the services of a person with expertise in long-term care insurance not affiliated with the issuer to conduct an examination of the policies (including its benefits, features, and rates) and update the examination thereafter in the event of material change;

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(ii) Actively monitor the marketing efforts of the issuer and its producers; and

(iii) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Subsections (3)(f)(i) through (f)(iii) of this section do not apply to qualified long-term care insurance policies.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the issuer files with the commissioner the information required in this subsection.

(h) The issuer must not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the issuer certifies annually that the association has complied with the requirements set forth in this section.

(i) Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-105, filed 11/24/08, effective 12/25/08.]

WAC 284-83-110 Suitability. (1) This section does not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every issuer or other entity marketing long-term care insurance must:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

(3)(a) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and the issuer must develop procedures that take the following into consideration:

(i) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(ii) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(iii) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The issuer, and if an insurance producer is involved, the insurance producer must make reasonable efforts to obtain the information set out in subsection (2)(a) of this section. The efforts must include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet." The personal worksheet used by the issuer must contain, at a minimum, the information in the format set forth in WAC 284-83-170, in not less than twelve point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the form of the issuer's personal worksheet must be filed with the commissioner.

(c) Except for sales of employer-group long-term care insurance to employees and their spouses, a completed personal worksheet must be returned to the issuer prior to the issuer's consideration of the applicant for coverage.

(d) The sale, distribution, use or dissemination in any way by the issuer or insurance producer of information obtained through the personal worksheet is prohibited.

(4) The issuer must use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to the applicant is appropriate.

(5) Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "things you should know before you buy long-term care insurance" must be provided. The form must be in the format set forth in WAC 284-83-175, in not less than twelve point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer may send the applicant a letter similar to the form set forth in WAC 284-83-180. If the applicant declines to provide financial information, the issuer may use another method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification must be made part of the applicant's file.

(8) The issuer must report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-110, filed 11/24/08, effective 12/25/08.]

WAC 284-83-115 Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-115, filed 11/24/08, effective 12/25/08.]

WAC 284-83-120 Availability of new services or providers. (1) The issuer must notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the issuer to the general public. The notice must be provided within twelve months after the date the new policy series is made available for sale in this state. Changes to policy structure or benefits or

provisions that are minor in nature are not "new long-term care services or providers material in nature." Examples of when notification need not be provided include changes in elimination periods, benefit periods or benefit amounts.

(2) Notwithstanding subsection (1) of this section, notification is not required for any long-term care insurance policy issued prior to January 1, 2009, or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy series. The issuer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium in order to add the new services or providers.

(3) The issuer must make the new coverage available in one of the following ways:

(a) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(b) By exchanging the existing policy or certificate for one with an issue age based on the attained age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits must be based on premiums paid or reserves held for the prior policy or certificate;

(c) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status is recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(d) By an alternative program developed by the issuer that meets the intent of this section if the program is filed with and approved by the commissioner.

(4) The issuer is not required to notify its policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means distribution through a discrete entity, such as a financial institution or brokerage, through which specialized products are made available that are not available for sale to the general public. Policyholders that purchase a new proprietary policy must be notified when a new long-term care policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(5) Policies issued pursuant to this section will be considered exchanges and not replacements. These exchanges are not subject to WAC 284-83-060 and 284-83-110, and the reporting requirements of WAC 284-83-065 (1) through (5).

(6)(a) If the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in subsection (1) of this section must be made to the offering entity.

(b) If the policy is issued to a group defined in RCW 48.83.020 (6)(d), the notification must be made to each certificateholder.

(2009 Ed.)

(7) Nothing in this section prohibits the issuer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. Upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The issuer may require the policyholder to meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.

(8) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-120, filed 11/24/08, effective 12/25/08.]

WAC 284-83-125 Right to reduce coverage and lower premiums. (1)(a) Every long-term care insurance policy and certificate must include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

(i) Reducing the maximum benefit; or

(ii) Reducing the daily, weekly or monthly benefit amount.

(b) The issuer may also offer other reduction options that are consistent with the policy or certificate design or the issuer's administrative processes.

(2) The provision must include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(3) The age to determine the premium for the reduced coverage must be based on the age used to determine the premiums for the coverage currently in force.

(4) The issuer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(5) If a policy or certificate is about to lapse, the issuer must provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by WAC 284-83-025 (1)(c).

(6) Compliance with this section may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy.

(7) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-125, filed 11/24/08, effective 12/25/08.]

WAC 284-83-130 Nonforfeiture benefit requirement. (1) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(2) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of RCW 48.83.120:

(a) A policy or certificate offered with nonforfeiture benefits must have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage issued by the issuer without nonforfeiture benefits. The nonforfeiture benefit included in the offer must be the benefit described in subsection (5) of this section; and

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(b) The offer must be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(3) If the offer required to be made under RCW 48.83.120 is rejected, the issuer must provide the contingent benefit upon lapse described in this section. The contingent benefit on lapse in subsection (4)(d) of this section applies even if this offer is accepted for a policy with a fixed or limited premium paying period.

(4)(a) After rejection of the offer required under RCW 48.83.120, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the issuer must provide a contingent benefit upon lapse.

(b) If a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) A contingent benefit on lapse must be triggered every time the issuer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, and the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%

Issue Age	Percent Increase Over Initial Premium
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) A contingent benefit on lapse must also be triggered for policies with a fixed or limited premium paying period every time the issuer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the following table based on the insured's issue age, the policy or certificate lapses within one hundred twenty days after the due date of the premium so increased, and the ratio in (f)(ii) of this subsection is forty percent or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the date the premium reflecting the rate increase is due. This requirement is in addition to the contingent benefit provided by subsection (3) of this section and if both are triggered, the benefit provided must be at the option of the insured.

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

(e) On or before the effective date of a substantial premium increase as defined in (c) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (5) of this section. This option may be elected at any time during the one hundred twenty-day period provided for in (c) of this subsection; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period provided for in (c) of this subsection will be deemed to be the election of the offer to convert in (e)(ii) of this subsection unless the automatic option in (f)(iii) of this subsection applies.

(f) On or before the effective date of a substantial premium increase as defined in (d) of this subsection, the issuer must:

(i) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(ii) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period provided for in (d) of this subsection; and

(iii) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period provided for in (d) of this subsection will be deemed to be the election of the offer to convert in (f)(ii) of this subsection if the ratio is forty percent or more.

(5) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (4)(c) but not (d) of this subsection, are described in this subsection:

(a) For purposes of this subsection, "attained age rating" is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

(b) For purposes of this subsection, the nonforfeiture benefit must be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits must be determined as specified in (c) of this subsection.

(c) The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The issuer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration; however, the minimum nonforfeiture credit must not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection (6) of this section.

(d)(i) The nonforfeiture benefit must begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse must be effective during the first three years as well as thereafter.

(ii) Notwithstanding (d)(i) of this subsection, for a policy or certificate with attained age rating, the nonforfeiture benefit must begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(6) All benefits paid by the issuer while the policy or certificate is in premium-paying status or in paid-up status must not exceed the maximum benefits that would be payable if the policy or certificate had remained in premium-paying status.

(7) No difference in the minimum nonforfeiture benefits as required under this section for group and individual policies is permitted.

(8) The requirements set forth in this section must become effective twelve months after adoption of this provision and must apply as follows:

(a) Except as provided in (b) and (c) of this subsection, this section applies to any long-term care policy issued in this state on or after January 1, 2009.

(b) This section does not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a), if policy was in force on January 1, 2009.

(c) The last sentence in subsection (3) of this section and subsection (4)(d) and (f) of this section apply to any long-term care insurance policy or certificate issued in this state six months after their adoption, except as to new certificates on a group policy as defined in RCW 48.83.020 (6)(a), those sentences apply to any long-term care insurance policy or certificate issued in this state one year after adoption.

(9) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse is subject to the loss ratio requirements of WAC 284-83-085 or 284-83-090, whichever is applicable, treating the policy as a whole.

(10) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (4)(c) or (d) of this section, a replacing issuer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another issuer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original issuer.

(11) A nonforfeiture benefit for qualified long-term care insurance policies that are level premium policies must be offered and must meet the following requirements:

(a) The nonforfeiture provision must be appropriately captioned;

(b) The nonforfeiture provision must provide a benefit available in the event of a default in the payment of any premiums and must state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying policies approved by the commissioner for the same policy form; and

(c) The nonforfeiture provision must provide at least one of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Shortened benefit period; or

(iv) Other similar offerings approved by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-130, filed 11/24/08, effective 12/25/08.]

WAC 284-83-135 Standards for benefit triggers. (1)

A long-term care insurance policy must condition the payment of benefits on a determination of the insured's ability to perform activities of daily living or on cognitive impairment of the insured. Eligibility for the payment of benefits must not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

(2)(a) Activities of daily living must include at least the following, as defined in WAC 284-83-015, and must be defined in the policy:

- (i) Bathing;
- (ii) Continence;
- (iii) Dressing;
- (iv) Eating;
- (v) Toileting; and
- (vi) Transferring;

(b) Issuers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (1)(a) of this section only if they are defined in the policy.

(3) The issuer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions must not restrict, and must not be in lieu of, the requirements contained in subsections (1) and (2) of this section.

(4) For purposes of this section the determination of a deficiency must not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Long-term care insurance policies must include a clear description of the process for appealing and resolving benefit determinations.

(7)(a) Except as provided in (b) of this subsection, the provisions of this section apply to a long-term care policy issued in this state on or after January 1, 2009.

(b) The provisions of this section do not apply to certificates issued on or after the effective date of this section under a group long-term care insurance policy as defined in RCW 48.83.020 (6)(a) that were in force on January 1, 2009.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-135, filed 11/24/08, effective 12/25/08.]

WAC 284-83-140 Qualified long-term care insurance policies—Additional standards for benefit triggers. (1)

For purposes of this section the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702 (c)(1) of the Internal Revenue Code of 1986, as amended, including: Necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b)(i) "Chronically ill individual" has the meaning of Section 7702B (c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

(A) Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term "chronically ill individual" does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in Section 1861 (r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the federal Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance policy must condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the federal Secretary of the Treasury.

(5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-140, filed 11/24/08, effective 12/25/08.]

WAC 284-83-145 Standard format outline of coverage. The following standards apply to the format and outline of coverage to be used in this state.

(1) The outline of coverage must be a free-standing document, using no smaller than ten-point type.

(2) The outline of coverage must contain no material of an advertising nature.

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other

means that provide prominence equivalent to the capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) The following format for outline of coverage must be used in this state:

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [Insert address].

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance policy, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY [OR CERTIFICATE] CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986 as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

(2009 Ed.)

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable must contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For insurance producers] neither [insert company name] nor its [agents] [insurance producers] represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment must be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers must accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be

increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-145, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-150 Requirement to deliver shopper's guide. (1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner, must be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of solicitations by an insurance producer, the insurance producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Issuers or insurance producers of life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the shopper's guide, but must furnish the policy summary required by RCW 48.83.070(2).

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-150, filed 11/24/08, effective 12/25/08.]

WAC 284-83-155 Prohibited practices. The following practices are prohibited:

(1) No insurance producer or other representative of the issuer may complete the medical history portion of any form or application, including an electronic application, for the purchase of a long-term care policy.

(2) No issuer or insurance producer or other representative of the issuer may knowingly sell a long-term care policy to any person who is receiving Medicaid.

(3) No issuer or insurance producer or other representative of the issuer may use or engage in any unfair or deceptive act or practice in the advertising, sale or marketing of long-term care policies.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-155, filed 11/24/08, effective 12/25/08.]

WAC 284-83-165 Form for reporting rescission of long-term care policies. The following form must be used by issuers to annually report rescission of long-term care policies.

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES FOR THE STATE
OF _____ FOR THE REPORTING YEAR 20[]

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

Instructions: The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

Signature

Name and Title (please type)

Date

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-165, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-170 Form of personal worksheet. The following form of personal worksheet must be used by issuers in the sale of long-term care insurance policies.

**Long-Term Care Insurance
Personal Worksheet**

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [\$_____ per month, or \$_____ per year,] [a one-time single premium of \$_____.]

Type of Policy (noncancellable or guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Issuers must use appropriate bracketed statement. Rate guarantees must not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

From my Income From my Savings/Investments My Family will Pay

[Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) Under \$10,000 \$[10-20,000] \$[20-30,000] \$[30-50,000] Over \$50,000

Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? From my Income From my Savings/Investments My Family will Pay

The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.

Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost \$_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From my Income From my Savings/Investments My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

Under \$20,000 \$20,000-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

The answers to the questions above describe my financial situation.

OR

I choose not to complete this information.

(Check one.)

I acknowledge that the issuer and/or its [agent] [insurance producer] (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed: _____
(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: _____
[(Agent)] [(Insurance Producer)] (Date)

[Agent's] [Insurance Producer's] Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My [agent] [insurance producer] has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]
(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or [agent] [insurance producer] sale.

The company may contact you to verify your answers.

Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-170, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-175 Disclosure form. The following form of disclosure must be used in this state.

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

[You should **not** buy this insurance policy unless you can afford to pay the premiums every year.]
[Remember that the company can increase premiums in the future.]

Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare Medicare does **not** pay for most long-term care.

Medicaid Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities Some long-term care insurance policies provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-175, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-180 Response letter. The following form of response letter must be used in this state.

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

Yes, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

No. I have decided not to buy a policy at this time.

APPLICANT'S SIGNATURE _____ DATE _____

Please return to [issuer] at [address] by [date].

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-180, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-185 Sample claims denial reporting form. The following form for reporting claims denials must be used in this state.

Claims Denial Reporting Form

Long-Term Care Insurance

For the State of _____

For the Reporting Year of _____

Company Name: _____

Due: June 30, annually

Company Address: _____

 Company NAIC Number: _____
 Contact Person: _____
 Phone Number: _____
 Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data ¹
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied Due to:		
8	• Long-Term Care Services Not Covered Under the Policy ²		
9	• Provider/Facility Not Qualified Under the Policy ³		
10	• Benefit Eligibility Criteria Not Met ⁴		
11	• Other		

Footnotes:

- The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
- Example—Home health care claim filed under a nursing home only policy.
- Example—A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
- Examples—A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-185, filed 11/24/08, effective 12/25/08.]

WAC 284-83-190 Potential rate increase disclosure form. The following form must be used in this state to disclose a potential rate increase.

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Issuers must provide all of the following information to the applicant:

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed] for an increase [is][are] [on the application][$\$$ _____]

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

This Policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture	
Cumulative Premium Increase Over Initial Premium	
That qualifies for Contingent Nonforfeiture	
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%

Issue Age	Percent Increase Over Initial Premium
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which WAC 284-83-130 (4)(d) and (f) are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect;

AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

• Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-190, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-195 Form for reporting replacement and lapse of long-term care insurance policies. The following form must be used in this state to report replacements and lapses of long-term care insurance.

Long-Term Care Insurance Replacement and Lapse Reporting Form

For the State of _____ For the Reporting Year of _____

Company Name: _____

Due: June 30, Annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every issuer must maintain records for each [agent] [insurance producer] on that [agent's] [insurance producer's] amount of long-term care insurance replacement sales as a percent of the [agent's] [insurance producer's] total annual sales and the amount of lapses of long-term care insurance policies sold by the [agent] [insurance producer] as a percent of the [agent's] [insurance producer's] total annual sales. The tables below should be used to report the ten percent of the issuer's [agents] [insurance producers] with the greatest percentages of replacements and lapses.

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Replacements

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Replaced by This [Agent] [Insurance Producer]	Number of Replacements as % of Number Sold by This [Agent] [Insurance Producer]

Listing of the 10% of [Agents] [Insurance Producers] with the Greatest Percentage of Lapses

[Agent's] [Insurance Producer's] Name	Number of Policies Sold by This [Agent] [Insurance Producer]	Number of Policies Lapsed by This [Agent] [Insurance Producer]	Number of Lapses as % of Number Sold by This [Agent] [Insurance Producer]

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales _____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year)____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-195, filed 11/24/08, effective 12/25/08.]

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

WAC 284-83-210 Definitions. For purposes of WAC 284-83-210 through 284-83-250:

(1) "Actual loss ratio" means a retrospective calculation and calculated as the benefits incurred divided by the "premi-

ums earned," both measured from the beginning of the calculating period to the date of the loss ratio calculations.

(2) "Benefits incurred" means the claims incurred plus any increase (or less any decrease) in the reserves.

(3) "Calculating period" means the time span over which the actuary expects the premium rates, whether level or increasing, to remain adequate in accordance with the actuary's best estimate of future experience and during which the actuary does not expect to request a rate increase.

(4) "Claims incurred" means:

- (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.

Claims incurred does 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.

(5) "Expected loss ratio" means a prospective calculation calculated as the projected benefits incurred divided by the projected premiums earned and based on the actuary's best projections of the future experience within the calculating period.

(6) "Overall loss ratio" means the benefits incurred divided by the premiums earned over the entire calculating period; it may involve both retrospective and prospective data.

(7) "Premium" means all sums charged, received or deposited as consideration for a long-term care insurance policy and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges paid.

(8) "Premiums earned" means the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

(9) "Reserves" includes:

- (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.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-210, filed 11/24/08, effective 12/25/08.]

WAC 284-83-220 Grouping of policy forms for purposes of ratemaking and requests for rate increase. (1) The actuary responsible for setting premium rates must group similar policy forms, including forms no longer being marketed, in the pricing calculations.

(a) The grouping must be satisfactory to the commissioner, who may rely on the judgment of the pricing actuary.

(b) Factors that must be considered include similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between policyholders.

(c) A grouping must enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination in violation of RCW 48.18.480.

(2009 Ed.)

(d) A grouping is not required to include forms issued by health care service contractors or health maintenance organizations before January 1, 1988.

(2) Persons insured under similar policy forms must be grouped at the time of ratemaking in accord with RCW 48.18.480 because they are expected to have substantially like insuring, risk and exposure factors and expense elements.

(a) The morbidity and mortality experience of these insureds, as a group, will deteriorate over time.

(b) A form may not be withdrawn from its assigned grouping by reason only of the deteriorating health of the people insured thereunder, as provided for in RCW 48.83.-170.

(3) One or more of the policy forms grouped for rate-making purposes, by random chance, may experience significantly higher or more frequent claims than the other forms. A form may not 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 generic policy forms and policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-220, filed 11/24/08, effective 12/25/08.]

WAC 284-83-225 Separation of data regarding certain policies. For reporting and record-keeping purposes, commencing with reports for accounting periods beginning on or after January 1, 2009, all issuers must separate data concerning long-term care insurance policies from data concerning other insurance policies.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-225, filed 11/24/08, effective 12/25/08.]

WAC 284-83-230 Loss ratio requirements for long-term care insurance forms. The following standards and requirements apply to long-term care insurance forms:

(1) Benefits for individual long-term care insurance forms will 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 issuer and satisfactory to the commissioner.

(2) Benefits for group long-term care insurance forms will be deemed reasonable in relation to the premiums if the overall loss ratio is at least seventy percent over a calculating period chosen by the issuer and satisfactory to the commissioner.

(3) The calculating period may vary with the benefit and renewal provisions. The issuer 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 must accompany the filing.

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(4) 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, must use a relatively short calculating period reflecting the uncertainties of estimating the risks involved.

(a) Policy forms based on more dependable statistics may employ a longer calculating period.

(b) The calculating period may be the lifetime of the policy for guaranteed renewable and noncancellable policy forms if these 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.

(c) The calculating period may be as short as one year for coverages that are based on statistics of minimal reliability or which are highly exposed to inflation.

(5) A request for a rate increase to be effective at the end of the calculating period must include a comparison of the actual to the expected loss ratios, must employ any accumulation of reserves in the determination of rates for the new calculating period, and must account for the maintenance of such reserves for future needs. The request for the rate increase must 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 must include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and must account for the maintenance of such reserves for future needs. If the experience justifies a premium increase, it will be deemed that the calculating period has prematurely been brought to an end. The rate increase must further be documented by the expected loss ratio for the next calculating period.

(7) Issuers must 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, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-230, filed 11/24/08, effective 12/25/08.]

WAC 284-83-240 Experience records. Issuers must maintain records of earned premiums and incurred benefits for each policy year for each contract, rider, endorsement and similar form which is combined for purposes of premium calculations, including the reserves. Records must 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, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-240, filed 11/24/08, effective 12/25/08.]

WAC 284-83-245 Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration will be given by the commissioner to all relevant factors including:

(1) Statistical credibility of premiums and benefits such as low expense 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, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-245, filed 11/24/08, effective 12/25/08.]

WAC 284-83-250 Life insurance policies that accelerate benefits for long-term care. (1) WAC 284-83-210 through 284-83-245 do not apply to life insurance policies that accelerate benefits for long-term care.

(2) A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of chapter 48.76 RCW;

(c) The policy meets the disclosure requirements of RCW 48.83.070(2) and 48.83.080;

(d) Any policy illustration that meets the applicable requirements of the chapter 48.23A RCW; and

(e) An actuarial memorandum is filed with the insurance department that includes:

(i) A description of the basis on which the long-term care rates were determined;

(ii) A description of the basis for the reserves;

(iii) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(iv) A description and a table of each actuarial assumption used. For expenses, the issuer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(v) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(vi) The estimated average annual premium per policy and the average issue age;

(vii) A statement as to whether underwriting is performed at the time of application. The statement must indicate whether underwriting is used and, if used, the statement must include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement must indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(viii) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-250, filed 11/24/08, effective 12/25/08.]

WAC 284-83-300 Standards for protecting patient privacy rights. Issuers must adopt and use administrative, business, and operational practices and procedures designed to protect an insured's right to privacy granted under chapter 70.02 RCW and federal laws and regulations. For example, issuers must not disclose the insured's health information without the written authorization of the insured, except where the recipient needs to know the information, such as:

(1) To any person, health care provider or health care facility that the issuer reasonably believes is providing health care to the insured;

(2) To any other person who requires health care information to provide planning, quality assurance, peer review, or administrative, legal, financial, billing or actuarial services;

(3) To assist a health care provider or health care facility in the delivery of health care and the issuer reasonably believes that the recipient will not use or disclose the health care information for any purpose other than the delivery of health care and will take appropriate steps to protect the information;

(4) To a health care provider or health care facility reasonably believed to have previously provided health care to the insured to the extent necessary to provide health care services, unless the insured has instructed the health care provider or health care facility in writing not to make the disclosure.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-300, filed 11/24/08, effective 12/25/08.]

WAC 284-83-310 Right of insureds to receive confidential health services. Issuers must adopt and use administrative, business, and operational practices and procedures to protect the insured's right to confidential health care services.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-310, filed 11/24/08, effective 12/25/08.]

WAC 284-83-320 Standards for the issuer's timely review of a claim denial. The following administrative, business, and operational standards must be used by issuers to ensure timely review of a claim denial.

(1) Issuers must have a fully operational, comprehensive claims denial review process.

(2) Issuers must implement procedures for registering and responding to oral and written requests for review of a claim denial in a timely and thorough manner.

(3) Issuers must provide written notice to the insured, to the insured's designated representative, and to the insured's provider of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued

stay in a health care facility or any other long-term care services or benefits.

(4) Issuers must process as an appeal an enrollee's written or oral request that the issuer reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. The issuer must not require that the insured file a complaint prior to seeking appeal of any such decision.

(5) The issuer must:

(a) Provide written notice to the insured when the appeal is received;

(b) Assist the insured with the appeal process;

(c) Make its decision regarding the appeal within thirty days after the date the appeal is received, except when a determination is made that the issuer's action must be expedited;

(d) Cooperate with a representative authorized in writing by the insured;

(e) Consider all information submitted by the insured;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the insured and, with the permission of the insured, to the insured's providers, that:

(i) Explains the issuer's decision and the supporting coverage or clinical reasons for the decision; and

(ii) If applicable, explains any further appeal process, including, if applicable, information about how to exercise the insured's rights to a second opinion and how to continue receiving or reinstate services.

(6) An appeal must be expedited if the insured's provider or the insured's medical director reasonably determines that following the appeal process, response timelines could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer.

(7) If the insured requests that the issuer reconsider its decision to modify, reduce, or terminate an otherwise covered health care service, and if the issuer's decision is based on the issuer's determination that the health service or level of health service is no longer covered, the issuer must continue to provide the health service until the appeal is resolved.

(8) Issuers must provide a clear explanation of their grievance processes and procedures at the time of application and upon request of the insured.

(9) Issuers must ensure that their grievance processes and procedures are accessible to insureds who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file a grievance.

(10) Issuers must track each appeal until final resolution and, upon request, make available to the commissioner a log of all appeals and grievances.

(11) Issuers must establish a process to identify and track problems encountered by enrollees when filing claims denials and, where appropriate, to make reasonable modifications to their appeals and grievance processes and procedures.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-320, filed 11/24/08, effective 12/25/08.]

WAC 284-83-350 Standard applied if there is a conflict between a master policy and certificate of insurance. If there is a discrepancy between a description of the terms and conditions of insurance between the master policy and any certificate issued under that master policy, the description most favorable to the insured must be used by the issuer and governs the matter.

[Statutory Authority: RCW 48.02.060, 48.83.070, 48.83.110, 48.83.120, 48.83.130(1), and 48.83.140 (4)(a). 08-24-019 (Matter No. R 2008-09), § 284-83-350, filed 11/24/08, effective 12/25/08.]

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 uni-

versal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

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

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

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

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

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

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

(8) "Death benefit corridor" defines a minimum policy benefit payable in addition to its cash value in the event of the death of the insured.

[Statutory Authority: RCW 48.02.060, 86-02-011 (Order R 85-5), § 284-84-020, filed 12/20/85.]

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

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

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

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

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

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

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

(f) r is equal to one.

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

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

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

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

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

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

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

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

(6) To the extent that the insurer declares guarantees more favorable than those in the policy (contractual guaran-

tees), 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.]

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Chapter 284-85 WAC

LONG-TERM CARE PARTNERSHIP

WAC

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WAC 284-85-005 Purpose and authority. This chapter is adopted pursuant to RCW 48.85.030 and 48.85.040. The purpose of this chapter is to effectuate chapter 48.85 RCW, the Washington Long-Term Care Partnership Act. Pursuant to RCW 48.85.030, this chapter establishes 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 partnership insurance and long-term care partnership policies, contracts and certificates. In addition, pursuant to RCW 48.85.040, this chapter sets standards and criteria for a consumer education program developed in cooperation with the state department of social and health services and members of the long-term care insurance industry. This program shall be designed to educate consumers as to the need for long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided by chapter 48.85 RCW.

Recognizing that the persons most likely to purchase long-term care partnership coverage are particularly sensitive to rate and premium increases, the goals of this chapter are: To ensure that long-term care partnership policies provide value to insureds both when issued and at time of claim; to encourage a competitive marketplace, stable premiums, and low-lapse rates; and to foster a long-term commitment to long-term care partnership coverage in this state by issuers of the coverage.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-005, filed 8/13/96, effective 9/13/96.]

WAC 284-85-010 Applicability and scope. (1) This chapter applies to all long-term care insurance policies, contracts, certificates, riders, and endorsements delivered or issued for delivery to a resident of this state or that provide coverage to a resident of this state, that claim to provide asset protection under the Washington Long-Term Care Partnership Act, chapter 48.85 RCW.

(2) This chapter shall not apply to medicare supplement policies regulated under chapter 48.66 RCW and chapter

284-55 or 284-66 WAC; policies or contracts between a continuing care retirement community and its residents; or to long-term care insurance policies that do not claim to provide asset protection under chapter 48.85 RCW.

(3) Policies claiming to provide asset protection under the Washington Long-Term Care Partnership Act that do not meet the requirements of this chapter may not be issued or delivered in this state.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-010, filed 8/13/96, effective 9/13/96.]

WAC 284-85-015 Standards for definitions used in this chapter and chapter 48.85 RCW. The following definitions are applicable to long-term care partnership policies, contracts, certificates, riders, and endorsements and the implementation of chapter 48.85 RCW. No contract may be advertised, solicited, or issued for delivery in this state as a long-term care partnership contract which uses definitions more restrictive or less favorable to an insured than the following:

(1) "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.

(2) "Advertising" is defined and described at RCW 48.30.040, 48.30.050, 48.30.080, 48.30.090 and WAC 284-50-030, 284-50-050, 284-50-060, 284-50-070, 284-50-080, 284-50-090, 284-50-100, 284-50-110, 284-50-120, 284-50-130, 284-50-140, 284-50-150, 284-50-160, 284-50-170, 284-50-180, 284-50-190 and 284-50-200. These standards are specifically incorporated in this chapter and shall apply to all long-term care contracts issued pursuant to this chapter and chapter 48.85 RCW.

(3) "Alternative plan of care" means a plan of health care or other care which provides a benefit to an insured and meets the standards of WAC 284-85-030(4).

(4) "Case manager" or "case coordinator" means an individual qualified by training 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 insured's attending physician or other primary care provider.

(5) "Case management services" includes, but is not limited to, a comprehensive individualized face-to-face assessment conducted in the insured's place of residence which takes an all-inclusive look at the patient's total needs and resources, and links the patient to a full range of appropriate services using all available funding sources. The assessment is reevaluated at least once every six months. When desired by the insured and when it is determined to be necessary by

the case manager, case management services shall include coordination of appropriate services and ongoing monitoring of the delivery of such services. For purposes of this chapter, case management services may, but need not, include deductibles or coinsurance provisions.

(6) "Contract" means long-term care partnership coverage, regardless of the kind of issuer, unless the context clearly indicates otherwise. The term specifically includes any policy, contract, certificate, rider, or endorsement delivered, issued for delivery, or that provides coverage to a resident of this state, if that contract claims to provide asset protection under the Washington Long-Term Care Partnership Act, chapter 48.85 RCW.

(7) "Direct response issuer" means an issuer 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.

(8) "Estate recovery" refers to the federal and state estate recovery program which requires recovery by the state from the insured's estate after the death of the insured, certain costs of services paid by the state during the lifetime of the insured (see: Chapter 43.20B RCW and chapter 388-527 WAC). The rules of the federal and state estate recovery program change from time to time; the rules in effect at the date of the insured's death will govern the estate recovery process.

(9) "Gatekeeper provision" has the meaning of WAC 284-54-160.

(10) "Guaranteed renewable" means that renewal of a contract may not be declined by an issuer for any reason except for nonpayment of premium; but the insurer may revise rates on a class basis with the prior written agreement of the commissioner.

(11) "Home and community-based care" means services including, but not limited to:

(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;

(f) Respite care;

(g) Adult day health care services;

(h) Community residential services, including but not limited to adult family homes, boarding homes, adult residential care, enhanced adult residential care, and assisted living; or

(i) Other similar services furnished in a home-like or residential setting.

Such services shall be provided at all levels of care from skilled care to custodial or personal care.

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

(13) "Insured" means any beneficiary of a long-term care partnership contract, regardless of the type of issuer.

(14) "Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of this state, any

contract that claims to provide asset protection under the Washington Long-Term Care Partnership Act, chapter 48.85 RCW. Issuer as used in this chapter specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

(15) "Long-term care contract" means a contract that is primarily advertised, marketed, or designed to provide coverage for or resulting from long-term care services over a prolonged period of time. Services provided may range from direct skilled medical care performed by trained medical professionals as prescribed by a physician or other primary care provider, or a qualified case manager, in consultation with the patient's attending physician or rehabilitative services or assistance with the basic necessary functions of daily living for people who have lost some or complete capacity to function on their own. This term also includes a contract that provides for payment of benefits based upon cognitive impairment or loss of functional capacity without regard to receipt of specific services.

(16) "Long-term care partnership contract" means a contract of long-term care insurance that claims to provide asset protection under the Washington Long-Term Care Partnership Act, chapter 48.85 RCW to a resident of this state.

(17) "Medicaid eligibility" means that an insured has exhausted the benefits of his or her long-term care partnership contract and it has been determined, in accordance with medicaid rules, that the insured is eligible for a medicaid program as determined by the state department of social and health services, or as provided in chapters 388-505 through 388-519 WAC.

(18) "Plan of care" means a written, individualized plan of services approved by the case manager that specifies the type, frequency, and providers of all formal and informal long-term care services required for the insured. Changes in the plan of care shall be documented to show alterations which have been agreed to and are required by a change in the situation or condition of the insured.

(19) "Premium" is defined and described at RCW 48.18-170, 48.18.180, and WAC 284-54-020(8).

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-015, filed 8/13/96, effective 9/13/96.]

WAC 284-85-030 Minimum standards for long-term care partnership policies. No long-term care partnership contract may be advertised, solicited, issued for delivery, or provide coverage to a resident of this state if it does not meet the following standards and the standards of chapter 48.85 RCW. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. Long-term care partnership contracts that provide for payment of benefits based on cognitive impairment or loss of functional capacity without regard to receipt of specific services are subject to the standards only of subsections (1), (2), (3), (5), and (6) of this section.

(1) Every long-term care partnership contract shall meet the standards for long-term care policies or contracts in chapters 48.84 and 48.85 RCW and chapter 284-54 WAC, unless specifically provided otherwise.

(2) All long-term care partnership contracts shall provide benefits for nursing home or institutional care.

(a) If the contract provides coverage for only nursing home or institutional care, that fact shall be prominently displayed on the first page of the contract form. Coverage in such policies shall include benefits for care received in alternative types of facilities or institutions if care is provided at a place where the patient incurs room and board charges.

(b) Pursuant to RCW 48.85.030, a long-term care partnership policy that provides coverage for only nursing home or institutional care benefits, shall provide for the written rejection of coverage or eligibility of coverage for home and community-based services as part of the application. A copy of the written rejection shall be made a part of the contract.

(3) Except upon the written rejection of the applicant or insured, every long-term care partnership contract shall include coverage for home and community-based services.

(4) Every long-term care partnership contract shall provide for an alternative plan of care benefit.

(a) This benefit shall be unstructured to allow for flexibility, to include coverage for types of care that might develop after the issue date of the insured's contract, and to allow for different levels of care with no requirement for prior confinement.

(b) This benefit shall not be designed or advertised as a substitute for home or community-based care.

(c) For example, this benefit might include, but need not be limited to, coverage for the following: Care provided in licensed or certified Alzheimer's centers, assisted living facilities, congregate care facilities, or similar arrangements, home-delivered meals or in-home safety devices. An issuer may limit such options by imposing a condition that such care be in a facility regulated by the state only if such class of facility is subject to state regulation.

(d) The alternate plan of care shall be agreeable to the insured's primary care giver, the issuer, and the insured, and shall be part of a plan of care developed by or with the assistance of health care professionals.

(5) Every long-term care partnership contract issued to an applicant age seventy-nine or younger shall provide inflation protection that automatically increases at a rate of no less than five percent annual percentage rate (APR). Inflation protection benefit increases shall continue without regard to an insured's age, claim status or claim history, or the length of time the insured has been insured under the contract.

(6) Every long-term care partnership contract shall provide benefits designed to provide coverage for an extended period of time.

(7) If nonforfeiture benefits are included, such benefits shall not be based on return of premium. All nonforfeiture benefits shall be consistent with asset protection purpose of long-term care partnership program, as determined by the commissioner.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-030, filed 8/13/96, effective 9/13/96.]

WAC 284-85-040 Standards related to rates. In order to assure stability of premiums and rates for long-term care partnership contracts, rates shall be designed to remain level over the life of the policy and shall be based on the insured's age at the time of application. Every rate filing of an issuer

shall be accompanied by a detailed explanation of how the issuer intends to comply with this section.

(1) Requests for rate increases must be actuarially supported to the satisfaction of the commissioner.

(2) All long-term care partnership contracts of an issuer shall be pooled together for purposes of rate making and may be pooled with the experience of long-term care contracts issued pursuant to chapter 48.84. RCW. Any pooling arrangement shall be approved in advance by the commissioner.

(3) No issuer may reduce or increase the rate of a long-term care partnership contract form except on the written, prior approval of the commissioner.

(4) Rate increases shall be made only on a class basis.

(5) The insured shall be notified in writing of the amount of any rate increase no fewer than sixty days in advance of charging an approved increase in rates and the insured shall be permitted to reduce contract benefits to defray the increased premium and guard against lapsation.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-040, filed 8/13/96, effective 9/13/96.]

WAC 284-85-045 Conversion from group to individual coverage or replacement of coverage. (1) If the insured is no longer eligible for group long-term care partnership coverage, the insured shall have the option to convert to an individual contract of long-term care insurance or to a long-term care partnership contract. The conversion policy offered shall include substantially similar benefits to the group contract. The insured shall not be required to provide evidence of good health or insurability. Such a transaction shall be treated as a conversion and the premium charged shall be based on either: The insured's original issue age of the long-term care partnership contract being converted, or the insured's attained age, if a credit is provided, either as to benefit or premium.

(2) Except where an individual is no longer eligible for group long-term care partnership coverage, and except as provided at WAC 284-85-055, no issuer may require an insured to convert his or her policy to a new form or benefit level.

(3) Insureds in claim status on the effective date of any conversion provided for by this section may be excluded. An issuer may provide that there will be no difference between the benefits of the prior contract and the benefits of the resulting contract.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-045, filed 8/13/96, effective 9/13/96.]

WAC 284-85-050 Disclosure and suitability standards. (1) At no time shall any statement contained in the contract, advertising related to solicitation or preservation of the contract, or representations made by the issuer or its agent, state or have the appearance of representing that the insured will be guaranteed to be automatically eligible for medicaid or that medicaid will deliver the same benefits as the insured's long-term care partnership policy.

(2) Every issuer and every agent shall make reasonable efforts to determine whether the issuance of a long-term care partnership policy will duplicate benefits under another dis-

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ability insurance policy, long-term care insurance contract, or duplicate other sources of coverage such as medicare supplemental insurance coverage; and shall take reasonable steps to determine that the purchase of the coverage being applied for is suitable for the applicant based on the financial circumstances of the applicant or insured.

(3) Every applicant shall be provided a copy of the long-term care partnership publication which is developed jointly by the commissioner and the department of social and health services no later than when the long-term care partnership application is signed by the applicant.

(4) Every long-term care partnership contract shall state that it is designed to qualify for medicaid asset protection on the first page of the contract. A similar statement shall be included on every application for a long-term care partnership contract and on any outline or summary of coverage provided to applicants or insureds.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-050, filed 8/13/96, effective 9/13/96.]

WAC 284-85-055 Termination of participation in the Washington long-term care partnership program. If an issuer terminates its participation in the Washington long-term care partnership program, the issuer shall cause as little disruption to insured residents of this state as possible. Such issuer shall first obtain written permission of the commissioner to cease the issuance of new long-term care partnership contracts. The issuer shall continue in force the then-existing contracts of insurance or may make arrangements satisfactory to the commissioner for another admitted issuer to assume all of the issuer's in force long-term care partnership policies. Such a transaction shall be subject to the assumption reinsurance rules for transfer of contracts of chapter 284-95 WAC, whereby the ceding issuer remains liable for obligations of the contract, unless issuer first obtains the written agreement of the insured to the transfer.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-055, filed 8/13/96, effective 9/13/96.]

WAC 284-85-060 Applications for long-term care partnership coverage. Every application shall be signed by the applicant and agent and shall certify that:

(1) The person received a description of the Washington long-term care partnership, the disclosure pamphlet set forth at WAC 284-85-050(3), including a description of the state's asset recovery program;

(2) The person understands that eligibility for medicaid upon exhaustion of the benefits of the long-term care partnership policy is neither guaranteed nor automatic;

(3) The person understands that the benefits provided under medicaid may not be the same as those provided under the long-term care partnership contract;

(4) The person agrees to permit the issuer to release information included in the application to the commissioner, solely for the purpose of data collection in preparation of the commissioner's report to the legislature, which release will advise the person that the issuer will act to preserve confidentiality of all medical information and document eligibility for

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the asset disregard provisions of medicaid and the department of social and health services; and

(5) If a person elects to purchase nursing home-only coverage, that the person understands that he or she has voluntarily waived coverage for home and community-based care.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-060, filed 8/13/96, effective 9/13/96.]

WAC 284-85-070 Advertising standards. Every issuer of long-term care partnership contracts shall submit its advertising materials to the commissioner no fewer than thirty days prior to use in this state. In addition to the standards of this chapter, all advertising materials are subject to the advertising rules in chapter 284-50 WAC.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-070, filed 8/13/96, effective 9/13/96.]

WAC 284-85-075 Summary of insurance benefits. (1) Upon request of an insured, an issuer shall prepare promptly a summary of the total services paid and the total amount of benefits remaining under the contract as of the date of the summary.

(2) A summary of insurance benefits paid and remaining shall be provided to the insured or his or her representative approximately ninety days prior to exhaustion of benefits.

(3) A reasonable fee may be charged for the preparation of a summary if requested more than once in any twelve-month period.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-075, filed 8/13/96, effective 9/13/96.]

WAC 284-85-080 Consumer education program. Issuers shall demonstrate to the satisfaction of the commissioner that they have and use procedures to provide notice to each purchaser of long-term care partnership insurance about the state's long-term care consumer education program. The program will include information regarding the need for long-term care, the methods of financing long-term care, the availability of long-term care insurance, the availability and eligibility requirements of the state's asset protection program, and the impact of this state's estate recovery rules.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-080, filed 8/13/96, effective 9/13/96.]

WAC 284-85-085 Standards for education of licensees soliciting long-term care partnership contracts. (1) Every issuer shall annually certify to the commissioner that each resident and nonresident licensee involved in the transaction of long-term care partnership insurance has completed an approved six-hour course on either long-term care partnership or long-term care partnership and long-term care every two years in accordance with WAC 284-17-220 (2)(b)(i). Applications may only be accepted if the licensee involved in the transaction meets the requirements of WAC 284-17-220 (2)(b)(i).

(2) Beginning with the calendar year 1998, issuers shall file a copy of the following certification report with the commissioner on or before March 31 of each year:

Annual Filing of Compliance with the
Long-Term Care and Long-Term Care Partnership
Education Requirements of WAC 284-17-220 (2)(b)(i)

To be filed with the commissioner on or before March 31 of each year

For the period of January 1 to December 31 of _____ (Year)

Company Name _____

Address _____

Insurance Policies Offered:

Long-Term Care _____ Long-Term Care Partnership _____ Both _____

I hereby certify that all our affiliated licenses involved in the transaction of each long-term care or long-term care partnership policy we issue in Washington fulfilled the requirements of WAC 284-17-220 (2)(b)(i). I certify that to the best of my knowledge, we did not accept or process any applications that involved the participation of a licensee who was not in compliance with WAC 284-17-220 (2)(b)(i).

Signature of Officer:

Date:

Name and Title of Officer:

Prepared by:

Phone Number:

Phone Number:

*Return Certification Form to:
Education Manager
Office of the Insurance Commissioner
P.O. Box 40257
Olympia, WA 98504-0257*

[Statutory Authority: RCW 48.02.060, 48.17.150 and 48.85.030. 97-19-007, § 284-85-085, filed 9/4/97, effective 10/5/97. Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-085, filed 8/13/96, effective 9/13/96.]

WAC 284-85-090 Standards for case management services. In order to assure covered services are used in a cost-effective and beneficial manner, objectivity in claims payment or benefit eligibility decisions, and to effectuate RCW 48.85.030 (2)(b), issuers that employ or contract with case managers shall:

(1) Demonstrate to the satisfaction of the commissioner that it has case management services sufficiently adequate to provide the necessary level of management throughout the state of Washington, that the case manager is able to supply or arrange for the recommended professional services in a plan of care, and that the case manager is able to adequately monitor the quality of services provided.

(2) Employ or contract with case management services that are objectively provided and demonstrate that the services provided are in the best interests of the insured.

(a) Case management services shall recognize the dignity of insureds. An insured or the insured's representative shall be provided sufficient information to make an informed choice of how to receive services, shall be permitted to participate in the development of the plan of care. The insured or the insured's representative shall be permitted access to the case record of the insured upon reasonable request.

(b) Case management services used by the issuer shall provide for a grievance or complaint procedure, the use of which is made known to the insured or the insured's representative.

(c) Each case manager shall exercise reasonable care to keep the insured's medical information confidential.

(d) The plan of care shall be agreed to in advance by the insured or the insured's representative, the issuer, and the insured's physician or primary care provider, and it shall be updated no less frequently than once every six months.

(e) In order to assure compliance with this chapter, the issuer shall make records of the case manager available to the commissioner upon request for purposes of audit.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-090, filed 8/13/96, effective 9/13/96.]

WAC 284-85-100 Recordkeeping. Issuers shall demonstrate to the satisfaction of the commissioner that they have procedures to provide for the special recordkeeping required by RCW 48.85.030 and this chapter.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-100, filed 8/13/96, effective 9/13/96.]

WAC 284-85-110 Records retention. Records of all policies issued shall be kept a minimum of ten years after exhaustion of benefits or nonrenewal, rescission, death of insured, or other termination of the contract by the issuer.

[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-110, filed 8/13/96, effective 9/13/96.]

WAC 284-85-900 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate a long-term care partnership contract under other sections of Title 48 RCW.

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[Statutory Authority: RCW 48.02.060, 48.17.150, 48.20.450, 48.85.030 and 48.85.040. 96-17-029 (Matter No. R 95-16), § 284-85-900, filed 8/13/96, effective 9/13/96.]

Chapter 284-87 WAC JOINT UNDERWRITING ASSOCIATION FOR MIDWIFERY AND BIRTHING CENTERS MALPRACTICE INSURANCE

WAC

284-87-010	Purpose.
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284-87-140	Cooperation of agents and brokers.
284-87-150	Commissions.
284-87-160	Additional notice required.
284-87-170	Termination of association.

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

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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 284-87-050 through 284-87-080, until it is activated by the commissioner as provided in WAC 284-87-040.

[Statutory Authority: RCW 48.02.060 and 48.87.100. 95-05-034, § 284-87-030, filed 2/8/95, effective 3/11/95; 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 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 administra-

tion, 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.

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(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.

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(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.]

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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.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-90-030	Policy reserves—Annual financial statements. [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.] Repealed by 00-20-105 (Matter No. R 2000-07), filed 10/4/00, effective 11/4/00. Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.01.030, 48.05.250, 48.18.110, 48.18.480.
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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. Related conditions include a positive testing for the Human Immunodeficiency Virus (HIV).

(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 subsidized 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, when health underwriting is not prohibited by rule or statute.

[Statutory Authority: RCW 48.02.060, 48.30.010, 48.44.050, 48.46.200, 48.01.030, 48.05.250, 48.18.110, 48.18.480. 00-20-105 (Matter No. R 2000-07), § 284-90-010, filed 10/4/00, effective 11/4/00. 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) Testing of insurance applicants must be administered on a nondiscriminatory basis. If a prospective insured is to be declined or rated substandard because of HIV infection, such action must be based on a Western Blot Test or any United States Food and Drug Administration approved confirmatory 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, 48.30.010, 48.44.050, 48.46.200, 48.01.030, 48.05.250, 48.18.110, 48.18.480. 00-20-105 (Matter No. R 2000-07), § 284-90-020, filed 10/4/00, effective 11/4/00. 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.]

Chapter 284-91 WAC

WASHINGTON STATE HEALTH INSURANCE POOL

WAC

284-91-001 Plan of operation approved.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-91-010 Board of directors. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-020 Organizational meeting, duties of board of directors. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-025 Plan of operation approved. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-030 Duties of administrator. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-040 Forms to be used by administrator. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-050 Involuntary terminations for other than nonpayment of premiums. [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.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

284-91-060 Eligibility in counties without commercially available coverage equivalent to pool coverage. [Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170 and 48.41.100. 99-18-039 (Matter No. R 99-4), § 284-91-060, filed 8/25/99, effective 9/25/99.] Repealed by 03-07-007 (Matter No. R 2001-15), filed 3/6/03, effective 4/6/03. Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020.

WAC 284-91-001 Plan of operation approved. Under RCW 48.41.040(4), the commissioner approves the plan of operation submitted by the board of directors of the Washington state health insurance pool (WSHIP). The plan of operation is composed of the following documents:

- (1) Articles of organization approved by the WSHIP board on September 5, 2002, and amended by the insurance commissioner on March 4, 2003;
- (2) Bylaws approved by the WSHIP board on September 5, 2002; and
- (3) Operating rules approved by the WSHIP board on September 5, 2002.

[Statutory Authority: RCW 48.02.060, 48.41.040, 48.41.170, 48.44.050, and 48.46.020. 03-07-007 (Matter No. R 2001-15), § 284-91-001, filed 3/6/03, effective 4/6/03.]

Chapter 284-92 WAC

LIABILITY RISK RETENTION

WAC

GENERAL

284-92-010
284-92-020

Definitions.
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PURCHASING GROUPS

284-92-210
284-92-220

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Registration effective upon notice by commissioner.

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284-92-240	Suspension and revocation of registration.
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284-92-410	Registration required.
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284-92-450	Agents.
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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.

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

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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, conservatorship, 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 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

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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.

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(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 RCW 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.

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(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.

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(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 sub-

stantially 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.

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[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.
284-96-550	Standard disclosure form for group coverage—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance.

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.]

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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.

(5) Whenever a covered person appeals the insurer's decision and delay would jeopardize the covered person's life or health, the group disability insurer must follow the appeal procedures and time frames in WAC 284-43-620(2).

[Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.43.055, 48.44.050, 48.46.100 and 48.46.200. 99-24-075 (Matter No. R 98-17), § 284-96-015, filed 11/29/99, effective 12/30/99. 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 treat-

ment 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.]

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.]

WAC 284-96-550 Standard disclosure form for group coverage—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. (1) All disability insurers offering group policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to the master

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policyholder at the time of solicitation and completion of the application form and to all enrollees at the time of enrollment. Every insurer must have a mechanism in place to verify delivery of the disclosure to the master policyholder and to every enrollee.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed for approval with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address)

**IMPORTANT INFORMATION ABOUT THE
COVERAGE 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 fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):
- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370, 07-21-073 (Matter No. R 2007-05), § 284-96-550, filed 10/15/07, effective 11/15/07.]

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Chapter 284-97 WAC

VIATICAL SETTLEMENT REGULATION

WAC

284-97-010	Purpose, scope, and effective date.
284-97-015	Definitions.
284-97-020	Licensing requirements for viatical settlement providers.
284-97-030	Licensing requirements for viatical settlement brokers.
284-97-040	Contract and rate filing requirements for viatical settlement providers and viatical settlement brokers.
284-97-050	Standards for evaluating reasonability of compensation.

WAC 284-97-010 Purpose, scope, and effective date.

(1) The purpose of this chapter is to effectuate chapter 48.102 RCW, by establishing minimum standards and disclosure requirements to be met by viatical settlement providers and viatical settlement brokers with respect to viatical settlement contracts advertised, solicited, or issued for delivery in this state, and licensing requirements for viatical settlement providers and viatical settlement brokers.

(2) Except as otherwise specifically provided, this chapter applies to every viatical settlement provider or viatical settlement broker as defined in RCW 48.102.005, that transacts viatical settlement business in this state on or after July 23, 1995. This chapter also applies to every viatical settlement contract executed between a viator and a viatical settlement provider in this state on or after July 23, 1995.

(3) This regulation is not exclusive, and acts or omissions, whether or not specific in this chapter, may also be violations of other sections of the insurance code or other regulations promulgated thereunder.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-010, filed 10/20/95, effective 11/20/95.]

WAC 284-97-015 Definitions. For purposes of this chapter:

(1) "Solicitation" means, for example; proposing, negotiating, signing, or doing any act in furtherance of making or proposing to make a viatical settlement contract. Solicitation specifically includes advertising by mail, use of the print or electronic media, telephone, or any other method of presenting, distributing, issuing, circulating, or permitting to be issued or circulated any information or material in connection with a viatical settlement contract.

(2) "Viatical settlement contract" has the meaning set forth at RCW 48.102.005(3). The commissioner finds that the purchase of a life insurance policy or certificate is outside the scope of this chapter if the viatical settlement contract is entered into between the viator and a close friend or relative.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-015, filed 10/20/95, effective 11/20/95.]

WAC 284-97-020 Licensing requirements for viatical settlement providers. (1) Beginning July 23, 1995, no individual, partnership, corporation, or other entity may act as a viatical settlement provider, or enter into or solicit a viatical settlement contract in this state unless it has first obtained a license from the commissioner.

(2) An initial application for licensing as a viatical settlement provider, or a subsequent application for reinstatement of a viatical settlement provider's license if the license has

lapsed for more than three months, shall be accompanied by a licensing fee in the amount of two hundred fifty dollars. The annual renewal fee shall be twenty-five dollars, due and payable on or before July 1 of each year.

(3) The application for a license as a viatical settlement provider shall furnish all of the applicable following information, on a form prescribed by the commissioner:

(a) The name of the applicant, its address, and organizational structure.

(b) Copies of its organizational documents, including but not limited to its: Articles of incorporation and any amendments thereto, certificate of incorporation and any amendments thereto, bylaws and any amendments thereto, partnership agreement and any amendments thereto, and articles of association and any amendments thereto.

(c) The identity of all: Stockholders holding ten percent or more of the voting securities; investors holding a ten percent or greater interest; partners; corporate officers; trustees; if an association, all of the members; and parent and affiliate entities, together with a chart showing the relationship of the applicant to any parent, affiliated or subsidiary entities.

(d) A list of all stockholders holding ten percent or more of the voting securities, investors holding a ten percent or greater interest, partners, and officers of any parent or affiliate entities.

(e) Biographical affidavits of all its officers, directors, investors holding a ten percent or greater interest, partners, and members (if an association).

(f) For domestic viatical settlement providers, fingerprint cards of all its officers, directors, trustees, investors holding a ten percent or greater interest, partners, and members (if an association).

(g) A list of states in which the viatical settlement provider is licensed on the date of application, a copy of each effective license, and a list of the states in which it is or was doing business.

(h) A list of all business licenses from any level of government, for which the applicant, its officers, partners, trustees, and members (if an association), have applied, together with a certificate of incorporation from the Washington secretary of state, and a statement showing the current status of any such licenses, such as whether it has been revoked or suspended.

(i) A report stating whether any formal or informal regulatory action, by any level of state or federal government, is pending or has been taken against the applicant or its officers, directors, trustees, investors holding a ten percent or greater interest, partners, or members (if an association).

(j) A report stating whether any criminal action or civil action has been taken, or is pending, against the applicant or its officers, directors, trustees, investors holding a ten percent or greater interest, partners, or members (if an association).

(k) A copy of its most recent financial and operating reports, audited and unaudited.

(l) Copies of documents filed with the federal Securities and Exchange Commission and any applicable state securities regulator.

(m) A detailed plan of operations for the applicant's business, including but not limited to information regarding or identification of the following items:

(i) Escrow accounts and banks;

(ii) Advertising, brokerage, or distribution system to be used;

(iii) Marketing techniques to be used;

(iv) Marketing training program; and

(v) Contract offering and servicing facilities.

(n) Appointment of the commissioner to receive service of process and a designation of the person to whom the commissioner shall forward legal process.

(o) Such other information as the commissioner may reasonably require.

(4) To qualify for authority to transact business as a viatical settlement provider, the applicant must possess unimpaired capital, and thereafter maintain unimpaired capital, in the amount of not less than one hundred fifty thousand dollars.

(5) Each viatical settlement provider holding a license in this state shall annually, on or before March 1 of each year, file with the commissioner an annual statement for the preceding calendar year. The annual statement shall be on a form prescribed by the commissioner.

(6) The commissioner may issue a temporary viatical settlement provider's license, that will expire no later than December 31, 1995, upon receipt and review of the application required in subsection (3) of this section. After reviewing the application, the commissioner may issue the viatical settlement provider's license, refuse to issue such license, or revoke the temporary viatical settlement provider's license.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10, 95-22-016 (Order R 95-2), § 284-97-020, filed 10/20/95, effective 11/20/95.]

WAC 284-97-030 Licensing requirements for viatical settlement brokers. On and after July 23, 1995, no person may act as a viatical settlement broker, or solicit, negotiate, or enter into viatical settlement contracts in this state, unless licensed as a viatical settlement broker by the commissioner. A viatical settlement broker shall be qualified as a life insurance agent and appointed as a viatical settlement broker by each viatical settlement provider represented.

(1) Each applicant for a viatical settlement broker's license shall:

(a) Complete an application form furnished by the commissioner. The form shall be accompanied by a license fee in the amount of one hundred dollars. Applicants shall answer inquiries concerning their identity, provide fingerprint cards, and supply information about personal and business history and experience.

(b) A viatical settlement broker shall be appointed by each viatical settlement provider he or she represents. An appointment request form and the appointment fee in the amount of twenty dollars shall be submitted with the application for licensing.

(c) Applicants for a firm or corporate license shall provide copies of articles of incorporation, partnership agreements, or other indicia of current legal status, as appropriate.

(d) Every individual who acts as a viatical settlement broker on behalf of a firm or corporation shall be licensed and affiliated with the entity represented prior to solicitation or negotiation of a viatical settlement contract. Each request by a firm or corporation for an affiliation certificate shall be accompanied by a twenty-dollar filing fee.

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(e) Applicants for a viatical settlement broker's license shall provide satisfactory evidence that no disciplinary action has resulted in the suspension or revocation of any federal or state license.

(f) Prior to application for a resident viatical settlement broker's license, an applicant shall pass the life insurance agent's examination in this state, but need not be licensed as a life insurance agent.

(g) Nonresident applicants may be licensed as viatical settlement brokers. Each nonresident applicant shall provide satisfactory proof that he or she has successfully passed a life insurance agent's examination in a state within the two-year period immediately preceding the date of the application, or that he or she holds a valid license as a life insurance agent or viatical settlement broker in his or her state of residence. In addition, the nonresident applicant shall certify that no disciplinary action has resulted in suspension or revocation of any federal or state license. Applicants for a nonresident viatical settlement broker's license shall designate and authorize the commissioner as his or her agent for service of process and shall specify the person to whom the commissioner shall forward legal process.

(2) A person applying for a viatical settlement broker's license who is transacting viatical settlement business on the effective date of this chapter, may apply to the commissioner for a temporary resident or nonresident viatical settlement broker's license. A temporary license may be issued by the commissioner if the person is otherwise eligible for such license but has not taken and passed a life insurance agent's examination in a state. The temporary license issued by the commissioner shall expire no later than December 31, 1995. After review of the application, the commissioner may issue the viatical settlement broker's license, refuse to issue such license, or revoke the temporary viatical settlement broker's license.

(3) A viatical settlement broker's license is renewable every two years, upon payment of a renewal fee in the amount of one hundred dollars. A viatical settlement broker's license expires on the licensee's month and day of birth plus one year from the date the license is first issued, if an individual, or two years from the issue date in the case of a firm or corporation. Failure to pay the renewal fee by the renewal date will automatically terminate the authority conferred by the license.

(4) Appointments of a viatical settlement broker expire on July 1 following their issue dates and every two years thereafter, unless previously cancelled or revoked.

(5) Affiliations expire on the renewal date for the licensed firm or corporation to which they apply, and expire every two years thereafter, unless previously cancelled or revoked.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10, 95-22-016 (Order R 95-2), § 284-97-030, filed 10/20/95, effective 11/20/95.]

WAC 284-97-040 Contract and rate filing requirements for viatical settlement providers and viatical settlement brokers. Beginning September 1, 1995, all viatical settlement contracts shall be approved by the commissioner prior to use in this state.

[Title 284 WAC—p. 451]

(1)(a) Every viatical settlement contract shall be in writing, in a type size of no less than ten points, shall be identified by a form number in the lower left-hand corner of the first page, and include the terms under which the viatical settlement provider will pay compensation (called by whatever name) to the viator in exchange for the assignment, transfer, sole devise, or bequest of the death benefit or assignment of ownership of the life insurance policy or certificate to the viatical settlement provider or viatical settlement broker.

(b) Every viatical settlement contract shall provide for payment to the viator in a lump sum and shall be voidable at the option of the viator if the agreed value is not paid in full within thirty days of the date the viatical settlement contract is executed by both the viator and the viatical settlement provider.

(c) Every viatical settlement contract shall provide for transfer of the entire life insurance policy: Provided, however, That if agreed to in writing by both the insurer and the viator, a stated dollar value which is less than the full face amount of the life insurance policy (less any outstanding loans) may be transferred if:

(i) The viatical settlement provider obtains a bond in favor of all beneficiaries of the policy other than the viatical settlement provider in an amount sufficient to guarantee the payment of all premium for the balance of the premium-paying period as calculated on the effective date of the life insurance policy; or

(ii) Another arrangement acceptable to the commissioner is made which guarantees that the insurance policy will remain in full force and effect for the protection of beneficiaries designated by the viator (other than the viatical settlement provider) until the death of the insured.

(2) The viatical settlement contract shall provide for rescission no less favorable to the viator than as set forth in RCW 48.102.040 (3) and (4). The rescission provision shall appear on the first page of the contract. It shall provide that if the insured dies during the period of time allowed for rescission, the contract will be terminated effective the date of application and the parties are returned to their original positions. The contract shall provide a method for giving notice of rescission. If notice of rescission is given by mail, it shall be deemed given when deposited in the United States mail, first class postage prepaid.

(3)(a) Each form of viatical settlement contract filed with the commissioner shall include all of the following:

(i) A viatical settlement contract, completed in John Doe fashion;

(ii) A copy of a viator's application, completed in John Doe fashion;

(iii) A copy of an "Insurance Commissioner's Worksheet" as described in WAC 284-97-050(3), completed in John Doe fashion;

(iv) A copy of any written disclosure material that will be provided to a viator as required by RCW 48.102.035; this written disclosure shall set forth the name, address, and telephone number of the viatical settlement provider; and

(v) A copy of the pricing memorandum.

(b) That portion of the disclosure notice warning of possible tax consequences and possible effects on eligibility for public funds shall be prominently displayed.

(c) The disclosure notice shall state that before entering into a viatical settlement contract, the viator should consult with his or her life insurance agent or life insurer to determine whether accelerated benefits are available.

(d) The disclosure notice shall contain the definition of accelerated benefits set forth in WAC 284-23-620(1) in its entirety.

(4) The viatical settlement contract shall specify any effect entering into the contract will have upon the continued availability of supplemental benefits or riders that are or may be attached to the life insurance policy that is the subject of the viatical settlement contract, including assigning the responsibility for the continued payment of premiums. The benefits and riders considered shall include, but need not be limited to, the following:

(a) Guaranteed insurability options;

(b) Accidental death benefits, or accidental death and dismemberment benefits;

(c) Disability income or loss of income protection;

(d) Waiver of premium or monthly deduction waiver; and

(e) Family, spousal, or children's riders or benefits.

(5) No viatical settlement contract may contain any limitation or restriction on the use of the proceeds by the viator.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10, 95-22-016 (Order R 95-2), § 284-97-040, filed 10/20/95, effective 11/20/95.]

WAC 284-97-050 Standards for evaluating reasonability of compensation. In order to assure that benefits offered to a viator are reasonable in relation to the rate, fee, or other compensation that is charged, any payout shall be no less than the greater of the amounts defined in subsections (1) and (2) of this section.

(1) Payouts shall be no less than the following percentage of the expected death benefit under the insurance policy, net of loans. The following are minimum standards and shall not be presumed to be proof of fairness as to any specific transaction.

(a) If the insured's life expectancy is less than twelve months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than seventy-five percent.

(b) If the insured's life expectancy is at least twelve months, but less than twenty-four months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than sixty-five percent.

(c) If the insured's life expectancy is at least twenty-four months, but less than thirty-six months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator shall be no less than fifty percent.

(d) If the insured's life expectancy is at least thirty-six months, then the percentage of the expected death benefit under the insurance policy, net of loans, to be received by the viator, shall be no less than thirty percent.

(2) Payouts shall be no less than the expected death benefit under the insurance policy, net of loans, reduced by the sum of the amounts described in (a), (b), and (c) of this subsection. (a) The viatical settlement provider may retain the

amounts it would be required to pay to the insurer to keep the policy in force during the period of time ending concurrently with the insured's life expectancy.

(b) The viatical settlement provider may retain an allowance of fifteen percent of the expected death benefit, net of loans, to provide for a risk charge and for its expenses and profit.

(c) The viatical settlement provider may retain an allowance for the time value of money. The interest rate to be used is fifteen percent per annum, compounded monthly. The calculation shall be performed on the basis that the viatical settlement provider pays the present value of the expected death benefit under the insurance policy, net of loans, reduced by the amounts defined in (a) and (b) of this subsection. The payment to the viator shall reflect an interest adjustment for the period of time beginning when the viator is paid and ending concurrently with the insured's life expectancy.

(3) The viatical settlement provider shall maintain for each viator, a document bearing the title, "Insurance Commissioner's Worksheet" for ten years after the death of the insured, or rescission of the contract. The viatical settlement contract shall provide that the viator may at any time obtain upon request, without charge, a copy of the "Insurance Commissioner's Worksheet," the purpose of which is to assure that benefits comply with this section. This provision shall appear on the same page or page following the first occurrence of the statement of the amount to be paid to the viator. In addition to identifying the insured, the "Insurance Commissioner's Worksheet" shall be dated and shall include the text shown in items (a) through (j) of this subsection.

(a) Line one shall state, "(1) Life expectancy (measured from the date the viator is paid) is n = _____ months."

(b) Line two shall state, "(2) Death benefit proceeds expected from insurer is \$_____."

(c) Line three shall state, "(3) Amount expected to be paid by company to insurer is \$_____." The viatical settlement provider may substitute its name for the word "company."

(d) Line four shall state, "(4) Allowance for risk, expenses and profit, 15% of (2), is \$_____."

(e) Line five shall state, "(5) Interest rate is 15%."

(f) Line six shall state, "(6) Line (2), net of allowance for interest, is $(2)/1.0125^n = \$_____$."

(g) Line seven shall state, "(7) Line (6), less (3) and less (4), is \$_____."

(h) Line eight shall state, "(8) Minimum percentage, 75%, 65%, 50%, or 30%, of (2) is \$_____."

(i) Line nine shall state, "(9) Minimum amount required by the commissioner, the greater of (7) or (8), is \$_____."

(j) Line ten shall state, "(10) Amount to be paid by company, no less than (9), is \$_____." The viatical settlement provider may substitute its name for the word "company."

(4) The viatical settlement provider shall enclose with the submission of a viatical settlement contract form, and with the submission of a rate revision, for approval prior to use in this state, a pricing memorandum providing a description of the method and assumptions used in determining the value to be paid viators. At the time of submission of a pricing memorandum or at the time of submission of any subsequent supporting documentation, the viatical settlement provider may request the commissioner to withhold that material

from public inspection in order to preserve trade secrets or prevent unfair competition, in accordance with RCW 48.02.-120(3). Each page covered by such request shall be clearly marked "confidentiality requested." The memorandum shall include a description, which may use reasonable ranges, of the following:

(a) The procedure used to determine the insured's life expectancy including medical evaluation and use of health care professionals in such evaluation;

(b) The portion of the discount (difference between the death benefit of the life insurance policy or certificate and viatical settlement provider payment) due to market value interest rate (current worth of money) and how this interest rate is determined;

(c) The portion of the discount due to agent or broker compensation paid by the viatical settlement provider;

(d) The portion of the discount that is the viatical settlement provider's operation costs in connection with viatical settlements, including acquisition and maintenance cost and risk charge;

(e) The portion of the discount due to other overhead costs and profit margin;

(f) The effect, if any, that policy loans, surrender charges, and the net cash surrender value in the insurance plan have on the pricing determination;

(g) How provision is made in the settlement determination for future insurance plan premiums, dividends or excess amounts, if any; and

(h) What provision, if any, is made in the settlement determination for supplemental insurance benefits or riders.

[Statutory Authority: RCW 48.02.060, 48.30.010 and 1995 c 161 §§ 2, 4, 5 and 10. 95-22-016 (Order R 95-2), § 284-97-050, filed 10/20/95, effective 11/20/95.]