

Dear Senators PATRICK, Agenbroad, Ward-Engelking, and
Representatives DIXON, DeMordaunt, Smith:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Insurance:

IDAPA 18.00.00 - Notice of Omnibus Rulemaking - Temporary and Proposed Rulemaking (Docket
No. 18-0000-1900).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 08/08/2019. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 09/06/2019.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4854, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Commerce & Human Resources Committee and the House Business Committee

FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen

DATE: July 22, 2019

SUBJECT: Department of Insurance

IDAPA 18.00.00 - Notice of Omnibus Rulemaking - Temporary and Proposed Rulemaking (Docket No. 18-0000-1900)

The Department of Insurance has submitted temporary and proposed rules that reauthorize and republish the following previously approved chapters under IDAPA 18:

18.01.48, Rule to Implement the Privacy of Consumer Financial Information, redesignated as IDAPA 18.01.01

18.01.19, Insurance Rates and Credit Rating, redesignated as IDAPA 18.02.01

18.01.20, Automobile Insurance Policies, redesignated as IDAPA 18.02.02

18.01.34, Certificate of Liability Insurance for Motor Vehicles, redesignated as IDAPA 18.02.03

18.01.09, Suitability in Annuity Transactions, hereby redesignated as IDAPA 18.03.01

18.01.13, Life Settlements, redesignated as IDAPA 18.03.02

18.01.16, Variable Contracts, redesignated as IDAPA 18.03.03

18.01.41, Replacement of Life Insurance and Annuities, redesignated as IDAPA 18.03.04

18.01.61, Credit Life and Credit Disability Insurance, redesignated as IDAPA 18.03.05

18.01.05, Health Carrier External Review, redesignated as IDAPA 18.04.01

18.01.06, Rule to Implement Uniform Coverage for Newborn and Newly Adopted Children, redesignated as IDAPA 18.04.02

18.01.24, Advertisement of Disability (Accident and Sickness) Insurance, redesignated as IDAPA 18.04.03

18.01.26, Rule to Implement the Managed Care Reform Act, redesignated as IDAPA 18.04.04

18.01.27, Self-Funded Health Care Plans Rule, redesignated as IDAPA 18.04.05

18.01.28, Governmental Self-Funded Employee Health Care Plans Rule, redesignated as IDAPA 18.04.06

18.01.29, Restrictions on Discretionary Clauses in Health Insurance Contracts, redesignated as IDAPA 18.04.07

18.01.30, Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule, redesignated as IDAPA 18.04.08

18.01.31, Complications of Pregnancy, redesignated as IDAPA 18.04.09

18.01.54, Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, redesignated as IDAPA 18.04.10

18.01.60, Long-Term Care Insurance Minimum Standards, redesignated as IDAPA 18.04.11

18.01.69, Rules Governing Small Employer Health Insurance, redesignated as IDAPA 18.04.12

Kristin Ford, Manager
Research & Legislation

Paul Headlee, Manager
Budget & Policy Analysis

April Renfro, Manager
Legislative Audits

Glenn Harris, Manager
Information Technology

18.01.70, Rules Governing Small Employer Health Insurance Availability Act Plan Design, redesignated as IDAPA 18.04.13
18.01.72, Rule to Implement the Individual Health Insurance Availability Act, redesignated as IDAPA 18.04.14
18.01.74, Coordination of Benefits, redesignated as IDAPA 18.04.15
18.01.01, Title Insurance Definition of Tract Indexes and Abstract Records, redesignated as IDAPA 18.05.01
18.01.25, Title Insurance and Title Insurance Agents and Escrow Officers, redesignated as IDAPA 18.05.02
18.01.56, Rebates and Illegal Inducements to Obtaining Title Insurance Business Rules, redesignated as IDAPA 18.05.03
18.01.04, Rules Pertaining to Bail Agents, redesignated as IDAPA 18.06.01
18.01.10, Producers Handling of Fiduciary Funds, redesignated as IDAPA 18.06.02
18.01.52, Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees, redesignated as IDAPA 18.06.03
18.01.53, Continuing Education, redesignated as IDAPA 18.06.04
18.01.64, Managing General Agents, redesignated as IDAPA 18.06.05
18.01.65, Rules for the Surplus Line Brokers, redesignated as IDAPA 18.06.06
18.01.23, Rules Pertaining to Idaho Acquisitions of Control and Insurance Holding Company Systems, redesignated as IDAPA 18.07.01
18.01.46, Recognition of New Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities and Pure Endowment Contracts, redesignated as IDAPA 18.07.02
18.01.47, Valuation of Life Insurance Policies Including the Introduction and Use of New Select Mortality Factors, redesignated as IDAPA 18.07.03
18.01.62, Annual Financial Reporting, redesignated as IDAPA 18.07.04
18.01.66, Director's Authority for Companies Deemed to be in Hazardous Financial Condition, redesignated as IDAPA 18.07.05
18.01.67, Rules Governing Life and Health Reinsurance Agreements, redesignated as IDAPA 18.07.06
18.01.68, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, redesignated as IDAPA 18.07.07
18.01.75, Credit for Reinsurance Rules, redesignated as IDAPA 18.07.08
18.01.76, Property and Casualty Actuarial Opinion Rule, redesignated as IDAPA 18.07.09
18.01.77, Actuarial Opinion and Memorandum Rule, redesignated as IDAPA 18.07.10
18.01.78, Mutual Insurance Holding Company Rules, redesignated as IDAPA 18.07.11
18.01.81, Corporate Governance Annual Disclosure, redesignated as IDAPA 18.07.12
18.01.50, Adoption of the International Fire Code, redesignated as IDAPA 18.08.01

These rules were previously analyzed and reviewed by the Legislative Services Office upon their initial promulgation. **However, changes from the previously approved rules are noted as follows:**

18.01.05

The following sections and appendices are being allowed to expire: 023.03, regarding a comment period; 023.04, regarding registration renewal; 030, regarding an effective date and grounds for disapproval; Appendix C-1, regarding authorization for release of medical records; and Appendix C-2, regarding authorization for release of drug or alcohol abuse records and psychotherapy notes.

18.01.13

The following section and appendices are being allowed to expire: 011.01, regarding producer licenses; Appendix A-1, regarding life settlement provider reports; Appendix A-2, regarding provider report instructions; Appendix A-3, regarding supplemental reports; Appendix A-4, regarding supplemental report instructions; Appendix B, regarding disclosure to policy owners; Appendix C, regarding disclosure to policy owners upon settlement; and Appendix D, regarding life settlement broker's disclosure.

18.01.16

The following sections are being allowed to expire: 011.04.b and 011.04.c, regarding requests made by the Director for statutes, rules, and biographical data; 017, regarding examination of agents and other persons; and 018, regarding sales practices.

18.01.25

Section 004.02, which prohibits title insurers from issuing title insurance binders, commitments, or preliminary reports in the absence of an order, appears to be new language. A previous Section 004.02, on rebates, discounts, and credits, appears to have been removed.

Section 005.01 includes new definitions. Some definitions have also been removed.

A previous Section 005.07, on abstract plant information, is being allowed to expire.

Section 006, which requires producers of title business to make disclosures of financial interest in a title entity when referring applicants to the entity, appears to be new language.

Section 007, on the information that must be disclosed, appears to be new language.

Section 008, which requires title entities to disclose to the Director those producers of title business that have interest in the title entity, appears to be new language.

A previous Section 011.07, on escrow audit, is being allowed to expire.

18.01.52

Section 010, which includes definitions, is being allowed to expire.

18.01.65

Section 004, which adopts three definitions, appears to be new language.

Section 005, in which the Department delegates responsibility for several activities to the Surplus Lines Association of Idaho, appears to be new language.

Section 010, in which the Department delegates responsibility for several activities to the Surplus Lines Association of Idaho, appears to be new language.

18.01.67

Section 013, on existing agreements, is being allowed to expire.

18.01.74

In Section 010.09, a definition of "high deductible health plan" has been added.

Additional changes of a nonsubstantive nature have been made. All rule changes appear to be within the Department's statutory authority.

cc: Department of Insurance
Dean L. Cameron

***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

DOCKET NO. 18-0000-1900

NOTICE OF OMNIBUS RULEMAKING – TEMPORARY AND PROPOSED RULEMAKING

EFFECTIVE DATE: The effective date of the temporary rules listed in the descriptive summary of this notice is June 30, 2019.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted temporary rules, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 41-211, 41-254, 41-515, 41-612, 41-1013, 41-1025, 41-1037, 41-1232, 41-1334, 41-1940, 41-1965, 41-2314, 41-3817, 41-4207, 41-4409, 41-4609, 41-4715, 41-5211, 41-6404, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This temporary and proposed rulemaking adopts and re-publishes the following existing and previously approved and codified chapters under IDAPA 18, rules of the Department of Insurance:

IDAPA 18

All Lines:

- 18.01.48, *Rule to Implement the Privacy of Consumer Financial Information*; All rules *except Subsection 010.05.b.* (hereby re-designated as **IDAPA 18.01.01**)

Property, Casualty, Automobile Insurance:

- 18.01.19, *Insurance Rates and Credit Rating*; (hereby re-designated as **IDAPA 18.02.01**)
- 18.01.20, *Automobile Insurance Policies*; All rules *except Subsections 001.02.a. - 001.02.e.* (hereby re-designated as **IDAPA 18.02.02**)
- 18.01.34, *Certificate of Liability Insurance for Motor Vehicles*; (hereby re-designated as **IDAPA 18.02.03**)

Life & Annuity:

- 18.01.09, *Suitability in Annuity Transactions*; (hereby re-designated as **IDAPA 18.03.01**)
- 18.01.13, *Life Settlements* – All rules *except Section 011.01 and Appendices A-1, A-2, A-3, A-4, B, C, and D*; (hereby re-designated as **IDAPA 18.03.02**)
- 18.01.16, *Variable Contracts* – All rules *except Subsections 011.04.b. and 04.c. and Sections 017, 018, and 019*; (hereby re-designated as **IDAPA 18.03.03**)
- 18.01.41, *Replacement of Life Insurance and Annuities*; (hereby re-designated as **IDAPA 18.03.04**)
- 18.01.61, *Credit Life and Credit Disability Insurance*; (hereby re-designated as **IDAPA 18.03.05**)

Health & Disability Insurance:

- 18.01.05, *Health Carrier External Review* – all rules *except Section/Subsections 023.03, 023.04, 030, and except Appendices C-1 and C-2*; (hereby re-designated as **IDAPA 18.04.01**)
- 18.01.06, *Rule to Implement Uniform Coverage for Newborn and Newly Adopted Children*; (hereby re-designated as **IDAPA 18.04.02**)
- 18.01.24, *Advertisement of Disability (Accident and Sickness) Insurance*; (hereby re-designated as **IDAPA 18.04.03**)
- 18.01.26, *Rule to Implement the Managed Care Reform Act*; (hereby re-designated as **IDAPA 18.04.04**)
- 18.01.27, *Self-Funded Health Care Plans Rule*; (hereby re-designated as **IDAPA 18.04.05**)
- 18.01.28, *Governmental Self-Funded Employee Health Care Plans Rule*; (hereby re-designated as **IDAPA 18.04.06**)

- 18.01.29, *Restrictions on Discretionary Clauses in Health Insurance Contracts*; (hereby re-designated as **IDAPA 18.04.07**)
- 18.01.30, *Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule*; (hereby re-designated as **IDAPA 18.04.08**)
- 18.01.31, *Complications of Pregnancy*; (hereby re-designated as **IDAPA 18.04.09**)
- 18.01.54, *Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act*; (hereby re-designated as **IDAPA 18.04.10**)
- 18.01.60, *Long-Term Care Insurance Minimum Standards*; (hereby re-designated as **IDAPA 18.04.11**)
- 18.01.69, *Rules Governing Small Employer Health Insurance*; (hereby re-designated as **IDAPA 18.04.12**)
- 18.01.70, *Rules Governing Small Employer Health Insurance Availability Act Plan Design*; (hereby re-designated as **IDAPA 18.04.13**)
- 18.01.72, *Rule to Implement the Individual Health Insurance Availability Act*; (hereby re-designated as **IDAPA 18.04.14**)
- 18.01.74, *Coordination of Benefits*; ass rules with the addition of **Section/Subsection 010.09, 011.a.viii., 022.03.b.ii.(6),023, and new section 024**; (hereby re-designated as **IDAPA 18.04.15**)

Title Insurance:

- 18.01.01, *Title Insurance Definition of Tract Indexes and Abstract Records*; (hereby re-designated as **IDAPA 18.05.01**)
- 18.01.25, *Title Insurance and Title Insurance Agents and Escrow Officers*; (hereby re-designated as **IDAPA 18.05.02**)
- 18.01.56, *Rebates and Illegal Inducements to Obtaining Title Insurance Business Rules*; (hereby re-designated as **IDAPA 18.05.03**)

Agents & Licensing:

- 18.01.04, *Rules Pertaining to Bail Agents*; (hereby re-designated as **IDAPA 18.06.01**)
- 18.01.10, *Producers Handling of Fiduciary Funds*; (hereby re-designated as **IDAPA 18.06.02**)
- 18.01.52, *Rules Governing Disclosure Requirements for Insurance Producers When Charging Fees*; (hereby re-designated as **IDAPA 18.06.03**)
- 18.01.53, *Continuing Education*; (hereby re-designated as **IDAPA 18.06.04**)
- 18.01.64, *Managing General Agents*; (hereby re-designated as **IDAPA 18.06.05**)
- 18.01.65, *Rules for the Surplus Line Brokers*; (hereby re-designated as **IDAPA 18.06.06**)

Company Operations & Solvency:

- 18.01.23, *Rules Pertaining to Idaho Acquisitions of Control and Insurance Holding Company Systems*; (hereby re-designated as **IDAPA 18.07.01**)
- 18.01.46, *Recognition of New Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities and Pure Endowment Contracts*; (hereby re-designated as **IDAPA 18.07.02**)
- 18.01.47, *Valuation of Life Insurance Policies Including the Introduction and Use of New Select Mortality Factors*; (hereby re-designated as **IDAPA 18.07.03**)
- 18.01.62, *Annual Financial Reporting*; (hereby re-designated as **IDAPA 18.07.04**)
- 18.01.66, *Director's Authority for Companies Deemed to be in Hazardous Financial Condition*; (hereby re-designated as **IDAPA 18.07.05**)
- 18.01.67, *Rules Governing Life and Health Reinsurance Agreements*; (hereby re-designated as **IDAPA 18.07.06**)
- 18.01.68, *Minimum Reserve Standards for Individual and Group Health Insurance Contracts*; (hereby re-designated as **IDAPA 18.07.07**)
- 18.01.75, *Credit for Reinsurance Rules*; (hereby re-designated as **IDAPA 18.07.08**)
- 18.01.76, *Property and Casualty Actuarial Opinion Rule*; (hereby re-designated as **IDAPA 18.07.09**)
- 18.01.77, *Actuarial Opinion and Memorandum Rule*; (hereby re-designated as **IDAPA 18.07.10**)
- 18.01.78, *Mutual Insurance Holding Company Rules*; (hereby re-designated as **IDAPA 18.07.11**)
- 18.01.81, *Corporate Governance Annual Disclosure*; (hereby re-designated as **IDAPA 18.07.12**)

State Fire Marshal:

- 18.01.50, *Adoption of the International Fire Code; with the exception of Section 004.*
(hereby re-designated as **IDAPA 18.08.01**)

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1) and 67-5226(2), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These temporary rules are necessary to protect the public health, safety, and welfare of the citizens of Idaho and confer a benefit on its citizens. These previously approved and codified rules implement the duly enacted laws of the state of Idaho, provide citizens with the detailed rules and standards for complying with those laws, and assist in the orderly execution and enforcement of those laws. The expiration of these rules without due consideration and processes would undermine the public health, safety and welfare of the citizens of Idaho and deprive them of the benefit intended by these rules. After close review, the temporary rules promulgated herein are necessary to ensure adequate protection to the insurance buying public by providing for consumer protection, appropriate guidance for producers, insurers and others licensed to transact insurance and for fire protection within the state. Many of these rules are necessary for the DOI to retain its accreditation. Without such accreditation, Idaho would lose carriers who would be forced to move out of state. The rules are requested to be renumbered and divided into categories for ease in knowing which rules apply to specific situations.

FEE SUMMARY: This rulemaking does not impose a fee or charge.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2020 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because of the need to adopt the rules as temporary, and because these existing chapters of IDAPA are being re-published and re-authorized. Negotiated rulemaking also is not feasible because of the need to implement these rules before they expire; the rules form the regulatory framework of the laws of this state and have been previously promulgated and reviewed by the Legislature pursuant to the Idaho Administrative Procedures Act, Chapter 52, Title 67, Idaho Code; and because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the temporary and proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Pamela Murray, (208) 334-4217, pamela.murray@doi.idaho.gov.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

Dated this 19th day of June, 2019.

Dean L. Cameron, Director
Idaho Department of Insurance
700 W. State Street, 3rd Floor

P.O. Box 83720
Boise, ID 83702-0043
Phone: (208) 334-4250
Fax: (208) 334-4398

**IDAPA 18
TITLE 01
CHAPTER 01**

18.01.01 – RULE TO IMPLEMENT THE PRIVACY OF CONSUMER FINANCIAL INFORMATION

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to the authority granted by Title 41, Chapter 13, Section 41-1334, Idaho Code. (5-3-03)

001. TITLE AND SCOPE.

01. Title. This chapter is titled IDAPA 18.01.01, “Rule to Implement the Privacy of Consumer Financial Information.” (5-3-03)

02. Scope. This rule governs the treatment of nonpublic personal financial information about individuals by all licensees of the Idaho Department of Insurance. This rule: (5-3-03)

- a.** Requires a licensee to provide notice to individuals about its privacy policies and practices; (5-3-03)
- b.** Describes the conditions under which a licensee may disclose nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; (5-3-03)
- c.** Provides methods for individuals to prevent a licensee from disclosing that information; and (5-3-03)
- d.** Includes examples and sample clauses that are not exclusive, but, to the extent applicable, will constitute compliance with this rule. (5-3-03)

03. Applicability. This rule applies to nonpublic personal financial information about individuals who obtain or are beneficiaries of products or services primarily for personal, family, or household purposes from licensees. This rule does not apply to information about companies or individuals who obtain products or services for business, commercial, or agricultural purposes. (5-3-03)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department of Insurance may have written statements that pertain to the interpretation of the rules in this chapter. Any written statements are available for review at the Department of Insurance, 700 W. State Street, Boise, ID 83720. (5-3-03)

003. ADMINISTRATIVE APPEALS.

All hearings before the Director of the Department of Insurance will be governed by Chapter 2, Title 41, and Chapter 52, Title 67, Idaho Code. Any appeal from a decision of the Director can be taken to District Court pursuant to Chapter 52, Title 67, Idaho Code and the Idaho Rules of Civil Procedure. (5-3-03)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (5-3-03)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS -- WEB ADDRESS.

- 01. Office Hours.** 8 a.m. to 5 p.m., except Saturday, Sunday and legal holidays. (5-3-03)
- 02. Mailing Address.** PO Box 83720, Boise, Idaho 83720-0043. (5-3-03)
- 03. Street Address.** 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (5-3-03)
- 04. Web Site Address.** The department’s website is <https://doi.idaho.gov>. (5-3-03)

006. PUBLIC RECORDS.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (5-3-03)

007. -- 009. (RESERVED)

010. DEFINITIONS -- A THROUGH D.

As used in this rule, unless the context requires otherwise: (5-3-03)

01. Affiliate. A company that controls, is controlled by, or is under common control with another company. (5-3-03)

02. Clear and Conspicuous. A notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice. Examples: (5-3-03)

a. Reasonably understandable. A notice is reasonably understandable if it: (5-3-03)

i. Presents the information in clear, concise sentences, paragraphs, and sections; (5-3-03)

ii. Uses short explanatory sentences or bullet lists whenever possible; (5-3-03)

iii. Uses definite, concrete, everyday words and active voice whenever possible; (5-3-03)

iv. Avoids multiple negatives; (5-3-03)

v. Avoids legal and highly technical business terminology whenever possible; and (5-3-03)

vi. Avoids explanations that are imprecise and readily subject to different interpretations. (5-3-03)

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: (5-3-03)

i. Uses a plain-language heading to call attention to the notice; (5-3-03)

ii. Uses a typeface and type size that are easy to read; (5-3-03)

iii. Provides wide margins and ample line spacing; (5-3-03)

iv. Uses boldface or italics for key words; and (5-3-03)

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. (5-3-03)

c. Notices on web sites. If a licensee provides a notice on a web page, the notice must call attention to the nature and significance of the information in the notice. The licensee must use 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: (5-3-03)

i. Place the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or (5-3-03)

ii. Place 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. (5-3-03)

03. Collect. 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. (5-3-03)

04. Company. A corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization. (5-3-03)

05. Consumer. 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: (5-3-03)

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. (5-3-03)

b. 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. (5-3-03)

c. An individual is a licensee's consumer if: (5-3-03)

i. The individual is: (5-3-03)

(1) An applicant for insurance prior to the inception of insurance coverage; (6-30-19)T

(2) A beneficiary of a life insurance policy underwritten by the licensee; (5-3-03)

(3) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or (5-3-03)

(4) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and (5-3-03)

iii. The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under Sections 450, 451 and 452 of this rule. (5-3-03)

d. If the licensee provides the initial, annual, and revised notices under Sections 100, 150, and 300 of this rule to the plan sponsor, group or blanket insurance policyholder, or group annuity contract holder, and if the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about an individual other than as permitted under Sections 450, 451, and 452 of this rule, an individual is not the consumer of the licensee solely because he is: (5-3-03)

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; or (5-3-03)

ii. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee. (5-3-03)

iii. A beneficiary in a workers' compensation plan. (5-3-03)

e. The individuals described in Subparagraphs 010.05.e.i. through 010.05.e.iii. of this rule are consumers of a licensee if the licensee does not meet all the conditions of Paragraph 010.05.e. In no event shall the individuals, solely by virtue of the status described in Subparagraphs 010.05.e.i. through 010.05.e.iii. of this rule, be deemed to be customers for purposes of this rule. (5-3-03)

f. An individual is not a licensee's consumer solely because he is a beneficiary of a trust for which the licensee is a trustee. (5-3-03)

g. An individual is not a licensee's consumer solely because he is designated the licensee as trustee for

a trust. (5-3-03)

06. Consumer Reporting Agency. Is the same meaning as found in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)). (5-3-03)

07. Control: (5-3-03)

a. Ownership, control, or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one (1) or more other persons; (5-3-03)

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 (5-3-03)

c. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines. (5-3-03)

08. Customer. A consumer who has a customer relationship with a licensee. (5-3-03)

09. Customer Relationship. A continuing relationship between a consumer and a licensee under which the licensee provides one (1) or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes. Examples: (5-3-03)

a. A consumer has a continuing relationship with a licensee if: (5-3-03)

i. The consumer is a current policyholder of an insurance product issued by or through the licensee; (5-3-03)
or

ii. The consumer obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee. (5-3-03)

b. A consumer does not have a continuing relationship with a licensee if: (5-3-03)

i. The consumer applies for insurance but does not purchase the insurance; (5-3-03)

ii. The licensee sells the consumer travel insurance in an isolated transaction; (5-3-03)

iii. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee; (5-3-03)

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; (5-3-03)

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; (5-3-03)

vi. The customer's policy is lapsed, expired, 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 (12) consecutive months, other than annual privacy notices, material required by law or rule, communication at the direction of a state or federal authority, or promotional materials; (5-3-03)

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 (5-3-03)

viii. 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. (5-3-03)

10. Director. The Director of the Idaho Department of Insurance. (5-3-03)

011. DEFINITIONS -- E THROUGH Z.

As used in this rule, unless the context requires otherwise: (5-3-03)

01. Financial Institution. Any institution that engages 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)). Financial institution does not include: (5-3-03)

a. 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.); (5-3-03)

b. 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 (5-3-03)

c. 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 the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party. (5-3-03)

02. Financial Product or Service. A 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. (5-3-03)

03. Insurance Product or Service. 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. (5-3-03)

04. Licensee. All licensed insurers, producers, and other persons licensed, or required to be licensed; authorized, or required to be authorized; or registered, or required to be registered, pursuant to Title 41 of the Idaho Code. (5-3-03)

a. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in this rule if the licensee is an employee, agent, or other representative of another licensee ("the principal") and: (5-3-03)

i. The principal otherwise complies with, and provides the notices required by, the provisions of this rule; and (5-3-03)

ii. The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this rule. (5-3-03)

b. Subject to Paragraph 011.04.c., "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Title 41, Chapter 12, Idaho Code. (5-3-03)

c. A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in this rule provided: (5-3-03)

d. Subject to Paragraph 011.04.e., "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed surplus lines broker in this state, but only in regard to the surplus lines placements placed pursuant to Title 41, Chapter 12, Idaho Code. (5-3-03)

e. A surplus lines broker or surplus lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in this rule provided: (5-3-03)

i. 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 Section 450, except as permitted by Section 451 or 452 of this rule; and (5-3-03)

ii. 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 sixteen (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. (5-3-03)

05. Nonaffiliated Third Party. (5-3-03)

a. Any person except: (5-3-03)

i. A licensee's affiliate; or (5-3-03)

ii. 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). (5-3-03)

b. 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)). (5-3-03)

06. Nonpublic Personal Information. Nonpublic personal financial information. (5-3-03)

a. Means: (5-3-03)

i. Personally identifiable financial information; and (5-3-03)

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. (5-3-03)

b. Nonpublic personal financial information does not include: (5-3-03)

i. Health information; (5-3-03)

ii. Publicly available information, except as included on a list described in Subparagraph 011.07.a.ii., of this rule; or (5-3-03)

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. (5-3-03)

c. Examples of lists: (5-3-03)

i. 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. (5-3-03)

ii. 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. (5-3-03)

07. Opt Out. 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 Sections 450, 451, and 452. (5-3-03)

08. Personally Identifiable Financial Information. (5-3-03)

a. Any information: (5-3-03)

i. A consumer provides to a licensee to obtain an insurance product or service from the licensee; (5-3-03)

ii. About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or (5-3-03)

iii. The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer. (5-3-03)

b. Examples of personally identifiable financial information: (5-3-03)

i. Information a consumer provides to a licensee on an application to obtain an insurance product or service; (5-3-03)

ii. Account balance information and payment history; (5-3-03)

iii. The fact that an individual is or has been one (1) of the licensee's customers or has obtained an insurance product or service from the licensee; (5-3-03)

iv. 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; (5-3-03)

v. 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; (5-3-03)

vi. Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and (5-3-03)

vii. Information from a consumer report. (5-3-03)

c. Personally identifiable financial information does not include: (5-3-03)

i. Health information; (5-3-03)

ii. A list of names and addresses of customers of an entity that is not a financial institution; and (5-3-03)

iii. 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. (5-3-03)

09. Publicly Available Information. (5-3-03)

a. Any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from: (5-3-03)

- i. Federal, state, or local government records; (5-3-03)
- ii. Widely distributed media; or (5-3-03)
- iii. Disclosures to the general public that are required to be made by federal, state or local law. (5-3-03)
- b.** 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: (5-3-03)
 - i. That the information is of the type that is available to the general public; and (5-3-03)
 - 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. (5-3-03)
- c.** Examples of publicly available information: (5-3-03)
 - i. Government records. Publicly available information in government records includes information in government real estate records and security interest filings. (5-3-03)
 - 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. (5-3-03)
 - iii. Reasonable basis. (5-3-03)
- (1) 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. (5-3-03)
- (2) 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 the licensee that the telephone number is not unlisted. (5-3-03)

012. -- 099. (RESERVED)

100. INITIAL PRIVACY NOTICE TO CONSUMERS REQUIRED.

01. Initial Notice Requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to: (5-3-03)

- 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 100.05 of this rule; and (5-3-03)
- 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 Sections 451 and 452. (5-3-03)

02. When Initial Notice to Consumer Not Required. A licensee is not required to provide an initial notice to a consumer under Paragraph 100.01.b. of this rule if: (5-3-03)

- a.** The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by Sections 451 and 452, and the licensee does not have a customer relationship with the consumer; or (5-3-03)
- 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. (5-3-03)

03. When Licensee Establishes a Customer Relationship. (5-3-03)

a. General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship. (5-3-03)

b. Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer: (5-3-03)

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 (5-3-03)

ii. Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee. (5-3-03)

04. 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 100.01 of this rule as follows: (5-3-03)

a. The licensee may provide a revised policy notice, under Section 300 that covers the customer's new insurance product or service; or (5-3-03)

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 100.01 of this rule. (5-3-03)

05. Exceptions Allowing Subsequent Delivery of Notice. (5-3-03)

a. A licensee may provide the initial notice required in Paragraph 100.01.a. of this rule within a reasonable time after the licensee establishes a customer relationship if: (5-3-03)

i. Establishing the customer relationship is not at the customer's election; or (5-3-03)

ii. Providing notice not later than 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. (5-3-03)

b. Examples of Exceptions: (5-3-03)

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. (5-3-03)

ii. Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer 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. (5-3-03)

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. (5-3-03)

06. Delivery. When a licensee is required to deliver an initial privacy notice, by Section 100, the licensee shall deliver it according to Section 350. If the licensee uses a short-form initial notice for non-customers according to Section 203, the licensee may deliver its privacy notice according to Subsection 203.03. (5-3-03)

101. -- 149. (RESERVED)

150. ANNUAL PRIVACY NOTICE TO CUSTOMERS REQUIRED.

01. General Rule. (5-3-03)

a. 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 (12) consecutive months during which that relationship exists. A licensee may define the twelve (12) consecutive-month period, but the licensee shall apply it to the customer on a consistent basis. (5-3-03)

b. Example. A licensee provides a notice annually if it defines the twelve (12) 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 (1), the licensee shall provide an annual notice to that customer by December 31 of year two (2). (5-3-03)

02. Exceptions: Termination of Customer Relationship and Duplicate Notices. (3-29-17)

a. 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. (5-3-03)

b. Examples: (5-3-03)

i. If the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee. (5-3-03)

ii. If the individual's policy is lapsed, expired 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 (12) consecutive-months, other than to provide annual privacy notices, material required by law or rule, or promotional materials. (5-3-03)

iii. 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. (5-3-03)

iv. 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. (5-3-03)

c. Notwithstanding Subsection 150.01.a., a licensee is not required to provide the annual privacy notice to a current customer if the licensee: (3-29-17)

i. Provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 450, 451, and 452; and (3-29-17)

ii. Has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with Section 100 or Section 150. (3-29-17)

03. Delivery. When a licensee is required by Section 150 to deliver an annual privacy notice, the licensee shall deliver it according to Section 350. (5-3-03)

151. -- 199. (RESERVED)

200. INFORMATION TO BE INCLUDED IN PRIVACY NOTICES.

The initial, annual and revised privacy notices that a licensee provides, under Sections 100, 150, and 300, must 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. (5-3-03)

01. Information Licensee Collects. The categories of nonpublic personal financial information that the licensee collects. (5-3-03)

02. Information Licensee Discloses. The categories of nonpublic personal financial information that the licensee discloses. (5-3-03)

03. Parties to Whom Licensee Discloses. 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 Sections 451 and 452. (5-3-03)

04. Disclosures of Information About Former Customers. 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 Sections 451 and 452. (5-3-03)

05. Disclosures Under Section 450. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 450 (and no other exception in Sections 451 and 452 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 shall be provided. (5-3-03)

06. Explanation of Right to Opt Out. An explanation of the consumer's right under Subsection 400.01 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. (5-3-03)

07. Disclosures Under Federal Law. 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); (5-3-03)

08. Confidentiality and Security Practices. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and (5-3-03)

09. Categories as Permitted by Law. Any disclosure that the licensee makes under Section 201 of this rule. (5-3-03)

201. DESCRIPTION OF PARTIES SUBJECT TO EXCEPTIONS.

If a licensee discloses nonpublic personal financial information as authorized under Sections 451 and 452, the licensee is not required to list those exceptions in the initial or annual privacy notices required by Sections 100 and 150. 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. (5-3-03)

202. SATISFYING THE PRIVACY NOTICE INFORMATION REQUIREMENTS -- EXAMPLES.

01. 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: (5-3-03)

a. Information from the consumer; (5-3-03)

b. Information about the consumer's transactions with the licensee or its affiliates; (5-3-03)

- c. Information about the consumer's transactions with nonaffiliated third parties; and (5-3-03)
- d. Information from a consumer reporting agency. (5-3-03)
- 02. Categories of Nonpublic Personal Financial Information a Licensee Discloses.** (5-3-03)
 - a. 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 Subsection 202.01 of this rule, as applicable, and provides a few examples to illustrate the types of information in each category. These might include: (5-3-03)
 - i. Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number; (5-3-03)
 - ii. Transaction information, such as information about balances, payment history and parties to the transaction; and (5-3-03)
 - iii. Information from consumer reports, such as a consumer's creditworthiness and credit history. (5-3-03)
 - (1) 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. (5-3-03)
 - (2) 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. (5-3-03)
- 03. Categories of Affiliates and Nonaffiliated Third Parties to Whom the Licensee Discloses.** (5-3-03)
 - a. A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage. (5-3-03)
 - b. 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. (5-3-03)
 - c. A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories. (5-3-03)
- 04. Disclosures Under Exception for Service Providers and Joint Marketers.** If a licensee discloses nonpublic personal financial information under the exception in Section 450 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 200.05 of this rule if it: (5-3-03)
 - a. 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 200.02 of this rule, as applicable; and (5-3-03)
 - b. States whether the third party is: (5-3-03)
 - i. A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or (5-3-03)

- ii. A financial institution with whom the licensee has a joint marketing agreement. (5-3-03)

05. 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 Sections 451 and 452, the licensee may simply state that fact, in addition to the information it shall provide under Subsections 200.01, 200.08, 200.09, and Section 201 of this rule. (5-3-03)

06. 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: (5-3-03)

- a. Describes in general terms who is authorized to have access to the information; and (5-3-03)
- b. 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. (5-3-03)

203. SHORT-FORM INITIAL NOTICE WITH OPT OUT NOTICE FOR NON-CUSTOMERS.

01. Short-Form Initial Notice Allowed. A licensee may satisfy the initial notice requirements in Paragraph 100.01.b. and Subsection 251.02, 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 Section 250. (5-3-03)

02. Short-Form Initial Notice Requirements. A short-form initial notice shall: (5-3-03)

- a. Be clear and conspicuous; (5-3-03)
- b. State that the licensee's privacy notice is available upon request; and (5-3-03)
- c. Explain a reasonable means by which the consumer may obtain that notice. (5-3-03)

03. Delivery of Short-Form Initial Notice. The licensee shall deliver its short-form initial notice according to Section 350. 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 Section 350. (5-3-03)

04. 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: (5-3-03)

- a. Provides a toll-free telephone number that the consumer may call to request the notice; or (5-3-03)
- b. For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request. (5-3-03)

204. FUTURE DISCLOSURES.

The licensee's notice may include: (5-3-03)

01. Nonpublic Personal Financial Information. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and (5-3-03)

02. Affiliates or Nonaffiliated Third Parties. 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. (5-3-03)

205. SAMPLE CLAUSES.

Sample clauses illustrating some of the notice content required by Section 200 are included in Appendix A of this

rule. (5-3-03)

206. -- 249. (RESERVED)

250. FORM OF OPT OUT NOTICE TO CONSUMERS.

01. Opt Out Notice Form. If a licensee is required to provide an opt out notice under Subsection 400.01, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under Section 400. The notice shall state: (5-3-03)

a. That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party; (5-3-03)

b. That the consumer has the right to opt out of that disclosure; and (5-3-03)

c. A reasonable means by which the consumer may exercise the opt out right. (5-3-03)

02. 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: (5-3-03)

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, and states that the consumer can opt out of the disclosure of that information; and (5-3-03)

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. (5-3-03)

03. Reasonable Means to Exercise an Opt Out Right. A licensee provides a reasonable means to exercise an opt out right if it: (5-3-03)

a. Designates check-off boxes in a prominent position on the relevant forms with the opt out notice; (5-3-03)

b. Includes a reply form together with the opt out notice; (5-3-03)

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 (5-3-03)

d. Provides a toll-free telephone number that consumers may call to opt out. (5-3-03)

04. Unreasonable Means of Opting Out. A licensee does not provide a reasonable means of opting out if: (5-3-03)

a. The only means of opting out is for the consumer to write his own letter to exercise the opt out right; or (5-3-03)

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. (5-3-03)

05. 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. (5-3-03)

251. PROVIDING OPT OUT NOTICE TO CONSUMERS AND COMPLYING WITH OPT OUT DIRECTION.

01. 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 Section 100. (5-3-03)

02. 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 Section 100, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically. (5-3-03)

03. Joint Relationships. (5-3-03)

a. If two (2) 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 Paragraph 251.03.e of this rule). (5-3-03)

b. Any of the joint consumers may exercise the right to opt out. The licensee may either: (5-3-03)

i. Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; (5-3-03)
or

ii. Permit each joint consumer to opt out separately. (5-3-03)

c. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one (1) of the joint consumers to opt out on behalf of all of the joint consumers. (5-3-03)

d. A licensee may not require all joint consumers to opt out before it implements any opt out direction. (5-3-03)

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: (5-3-03)

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. (5-3-03)

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. (5-3-03)

iii. Permit John and Mary to make different opt out directions. If the licensee does so: (5-3-03)

(1) It shall permit John and Mary to opt out for each other; (5-3-03)

(2) 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 (5-3-03)

(3) 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. (5-3-03)

04. 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. (5-3-03)

05. Continuing Right to Opt Out. A consumer may exercise the right to opt out at any time. (5-3-03)

06. Duration of Consumer's Opt Out Direction. (5-3-03)

a. A consumer's direction to opt out under Sections 250 and 251 is effective until the consumer

revokes it in writing or, if the consumer agrees, electronically. (5-3-03)

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. (5-3-03)

07. Delivery. When a licensee is required to deliver an opt out notice by Section 250, the licensee shall deliver it according to Section 350. (5-3-03)

252. -- 299. (RESERVED)

300. REVISED PRIVACY NOTICES.

01. General Rule. Except as otherwise authorized in this rule, 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 Section 100, unless: (5-3-03)

a. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices; (5-3-03)

b. The licensee has provided to the consumer a new opt out notice; (5-3-03)

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 (5-3-03)

d. The consumer does not opt out. (5-3-03)

02. Examples of Application of General Rule. (5-3-03)

a. Except as otherwise permitted by Sections 450, 451, and 452, a licensee shall provide a revised notice before it: (5-3-03)

i. Discloses a new category of nonpublic personal financial information to any nonaffiliated third party; (5-3-03)

ii. Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or (5-3-03)

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. (5-3-03)

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. (5-3-03)

03. Delivery. When a licensee is required to deliver a revised privacy notice by Section 300, the licensee shall deliver it according to Section 350. (5-3-03)

301. -- 349. (RESERVED)

350. DELIVERY.

01. How to Provide Notices. A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically. (5-3-03)

- 02. Examples of Reasonable and Unreasonable Expectation of Actual Notice.** (5-3-03)
- a.** A licensee may reasonably expect that a consumer will receive actual notice if the licensee: (5-3-03)
- i.** Hand-delivers a printed copy of the notice to the consumer; (5-3-03)
- 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; (5-3-03)
- 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; or (5-3-03)
- 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. (5-3-03)
- b.** A licensee may not reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it: (5-3-03)
- i.** Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or (5-3-03)
- ii.** Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically. (5-3-03)
- 03. Annual Notices Only.** A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if: (5-3-03)
- 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 (5-3-03)
- 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. (5-3-03)
- 04. Oral Description of Notice Insufficient.** A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone. (5-3-03)
- 05. Retention or Accessibility of Notices for Customers.** (5-3-03)
- a.** For customers only, a licensee shall provide the initial notice required by Paragraph 100.01.a., the annual notice required by Paragraph 150.01.a, and the revised notice required by Section 300 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically. (5-3-03)
- 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: (5-3-03)
- i.** Hand-delivers a printed copy of the notice to the customer; (5-3-03)
- ii.** Mails a printed copy of the notice to the last known address of the customer; or (5-3-03)
- 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.

(5-3-03)

06. Joint Notice with Other Financial Institutions. A licensee may provide a joint notice from the licensee and one (1) 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. (5-3-03)

07. Joint Relationships. If two (2) 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 Subsections 100.01, 150.01, and 300.01, respectively, by providing one (1) notice to those consumers jointly. (5-3-03)

351. -- 399. (RESERVED)

400. LIMITS ON DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION TO NONAFFILIATED THIRD PARTIES.

01. Conditions for Disclosure. (5-3-03)

a. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless: (5-3-03)

i. The licensee has provided to the consumer an initial notice as required under Section 100; (5-3-03)

ii. The licensee has provided to the consumer an opt out notice as required in Sections 250 and 251; (5-3-03)

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 (5-3-03)

iv. The consumer does not opt out. (5-3-03)

b. If a consumer opts out, the licensee may not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 450, 451, and 452. (5-3-03)

c. Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if: (5-3-03)

i. By mail. The licensee mails the notices required in Subsection 400.01 of this rule 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 (30) days from the date the licensee mailed the notices. (5-3-03)

ii. By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Subsection 400.01 of this rule electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account. (5-3-03)

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 Subsection 400.01 of this rule 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. (5-3-03)

02. Application of Opt Out to All Consumers and All Nonpublic Personal Financial Information. (5-3-03)

a. A licensee shall comply with Section 400, regardless of whether the licensee and the consumer have established a customer relationship. (5-3-03)

b. Unless a licensee complies with Section 400, 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. (5-3-03)

03. 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. (5-3-03)

401. LIMITS ON REDISCLOSURE AND REUSE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.

01. Information the Licensee Receives Under an Exception. (5-3-03)

a. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in Sections 451 or 452 of this rule, the licensee's disclosure and use of that information is limited as follows: (5-3-03)

i. The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information; (5-3-03)

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 (5-3-03)

iii. The licensee may disclose and use the information pursuant to an exception in Section 451 or 452 of this rule, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information. (5-3-03)

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. (5-3-03)

02. Information a Licensee Receives Outside of an Exception. (5-3-03)

a. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in Section 451 or 452 of this rule, the licensee may disclose the information only: (5-3-03)

i. To the affiliates of the financial institution from which the licensee received the information; (5-3-03)

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 (5-3-03)

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. (5-3-03)

b. Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in Section 451 or 452: (5-3-03)

i. The licensee may use that list for its own purposes; and (5-3-03)

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

Section 451 or 452, such as to the licensee's attorneys or accountants. (5-3-03)

03. Information a Licensee Discloses Under an Exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in Section 451 or 452 of this rule, the third party may disclose and use that information only as follows: (5-3-03)

a. The third party may disclose the information to the licensee's affiliates; (5-3-03)

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 (5-3-03)

c. The third party may disclose and use the information pursuant to an exception in Section 451 or 452 in the ordinary course of business to carry out the activity covered by the exception under which it received the information. (5-3-03)

04. 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 Section 451 or 452 of this rule, the third party may disclose the information only: (5-3-03)

a. To the licensee's affiliates; (5-3-03)

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 (5-3-03)

c. To any other person, if the disclosure would be lawful if the licensee made it directly to that person. (5-3-03)

402. LIMITS ON SHARING ACCOUNT NUMBER INFORMATION FOR MARKETING PURPOSES.

01. General Prohibition on Disclosure of Account Numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer 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. (5-3-03)

02. Exceptions. Subsection 402.01 of this rule does not apply if a licensee discloses a policy number or similar form of access number or access code: (5-3-03)

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; (5-3-03)

b. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or (5-3-03)

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. (5-3-03)

03. Examples of Information Not Considered to Be a Policy Number or Account. (5-3-03)

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. (5-3-03)

b. Policy or transaction account. For the purposes of Section 402, 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. (5-3-03)

403. -- 449. (RESERVED)

450. EXCEPTION TO OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR SERVICE PROVIDERS AND JOINT MARKETING.

01. General Rule. (5-3-03)

a. The opt out requirements in Sections 250, 251 and 400 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: (5-3-03)

i. Provides the initial notice in accordance with Section 100; and (5-3-03)

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 Section 451 or 452 in the ordinary course of business to carry out those purposes. (5-3-03)

b. Example. If a licensee discloses nonpublic personal financial information under Section 450 to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of Subparagraph 450.01.a.ii. of this rule 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 Section 451 or 452 in the ordinary course of business to carry out that joint marketing. (5-3-03)

02. Service May Include Joint Marketing. The services a nonaffiliated third party performs for a licensee under Subsection 450.01 of this rule may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to a written agreement between the licensee and one (1) or more financial institutions to jointly offer, endorse, or sponsor a financial product or service. (5-3-03)

451. EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION FOR PROCESSING AND SERVICING TRANSACTIONS.

01. Exceptions for Processing Transactions at Consumer's Request. The requirements for initial notice in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 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: (5-3-03)

a. Servicing or processing an insurance product or service that a consumer requests or authorizes; (5-3-03)

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; (5-3-03)

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 (5-3-03)

d. Reinsurance or stop loss or excess loss insurance. (5-3-03)

02. Necessary to Effect, Administer or Enforce a Transaction. Necessary to effect, administer or enforce a transaction means that the disclosure is: (5-3-03)

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 (5-3-03)

- b.** Required, or is a usual, appropriate or acceptable method: (5-3-03)

 - 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; (5-3-03)
 - ii. To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part; (5-3-03)
 - 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; (5-3-03)
 - iv. To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party; (5-3-03)
 - v. To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer'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 (5-3-03)
 - vi. In connection with: (5-3-03)

 - (1) 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; (5-3-03)
 - (2) The transfer of receivables, accounts, or interests therein; or (5-3-03)
 - (3) The audit of debit, credit, or other payment information. (5-3-03)

452. OTHER EXCEPTIONS TO NOTICE AND OPT OUT REQUIREMENTS FOR DISCLOSURE OF NONPUBLIC PERSONAL FINANCIAL INFORMATION.

01. Exceptions to Opt Out Requirements. The requirements for initial notice to consumers in Paragraph 100.01.b., the opt out in Sections 250, 251, and 400, and service providers and joint marketing in Section 450 do not apply when a licensee discloses nonpublic personal financial information: (5-3-03)

- a.** With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction; (5-3-03)
- b.** To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction; (5-3-03)
- c.** To protect against or prevent actual or potential fraud or unauthorized transactions; (5-3-03)
- d.** For required institutional risk control or for resolving consumer disputes or inquiries; (5-3-03)
- e.** To persons holding a legal or beneficial interest relating to the consumer; or (5-3-03)
- f.** To persons acting in a fiduciary or representative capacity on behalf of the consumer; (5-3-03)
- g.** 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; (5-3-03)
- h.** 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, and the Federal Trade Commission), 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, self-regulatory organizations or for an investigation on a matter related to public safety; (5-3-03)

i. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or from a consumer report reported by a consumer reporting agency; (5-3-03)

j. 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; (5-3-03)

k. To comply with federal, state or local laws, rules, and other applicable legal requirements; to comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; (5-3-03)

l. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan; or (5-3-03)

m. With the consent of or at the direction of a liquidator or rehabilitator appointed pursuant to Chapter 33, Title 41, Idaho Code. (5-3-03)

02. 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 Subsection 251.05. (5-3-03)

453. -- 499. (RESERVED)

500. PROTECTION OF FAIR CREDIT REPORTING ACT.

Nothing in this rule 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 rule regarding whether information is transaction or experience information under Section 603 of that Act. (5-3-03)

501. NONDISCRIMINATION.

A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his nonpublic personal financial information pursuant to the provisions of this rule. (5-3-03)

502. VIOLATION.

Any person who releases nonpublic personal information in violation of these rules, or otherwise fails to comply with these rules, may be found by the Director to be in violation of Chapter 13, Title 41, Idaho Code, and subject to penalties as set forth in that chapter. (5-3-03)

503. -- 999. (RESERVED)

Appendix A -- 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 nonaffiliated third parties.)

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

A licensee may use this clause, as applicable, to meet the requirement to describe the categories 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 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 Sections 450, 451, and 452.

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 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 Sections 451 and 452.

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 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 Sections 450, 451, and 452, as well as when permitted by the exceptions in Sections 451 and 452.

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”];
Non-financial companies, such as [provide illustrative examples, such as “retailers, direct marketers, airlines, and publishers”]; and
Others, such as [provide illustrative examples, such as “non-profit 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 related to the exception for service providers and joint marketers in Section 450. 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 which 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 which 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 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 by the exceptions in Sections 450, 451, and 452.

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 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 rules to guard your nonpublic personal information.

**IDAPA 18
TITLE 02
CHAPTER 01**

18.02.01 – INSURANCE RATES AND CREDIT RATING

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to the authority granted by Title 41, Sections 41-211 and 41-1843, Idaho Code. (3-20-04)

001. TITLE AND SCOPE.

01. Title. This chapter is titled IDAPA 18.02.01, “Insurance Rates and Credit Rating.” (3-20-04)

02. Scope. This rule implements Section 41-1843, Idaho Code, enacted as Senate Bill No. 1408 by the legislature in 2002 relating to the use of credit rating or credit history by insurers in determining rating and coverage of insurance. (3-20-04)

002. WRITTEN INTERPRETATIONS.

The Department of Insurance may have written statements that pertain to the interpretation of the rules in this chapter. Any written statements are be available for review. (3-20-04)

003. ADMINISTRATIVE APPEALS.

All hearings before the Director of the Department of Insurance shall be governed by Chapter 2, Title 41, and Chapter 52, Title 67, Idaho Code. Any appeal from a decision of the Director can be taken to District Court pursuant to Chapter 52, Title 67, Idaho Code and the Idaho Rules of Civil Procedure. (3-20-04)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (3-20-04)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS -- WEB ADDRESS.

This office is open from 8 a.m. to 5 p.m., except Saturday, Sunday and legal holidays. The department’s mailing address is PO Box 83720, Boise, Idaho 83720-0043. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. The department’s website is <http://www.doi.idaho.gov>. (3-20-04)

006. PUBLIC RECORDS.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, and Title 41, Idaho Code. (3-20-04)

007. – 009. (RESERVED)

010. DEFINITIONS.

As used in this rule, unless the context requires otherwise, the following words have the following meanings: (3-20-04)

01. Consumer Report. Any written, oral, or other communication of any information by a consumer reporting agency regulated under the federal Fair Credit Reporting Act (15 U.S.C. 1681) that bears on a consumer’s credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. (3-20-04)

02. Credit Factor. A factor or criterion that consists of or is derived from information obtained from a consumer report that is used by an insurer in determining policy premium rates, or in determining whether to issue, cancel or nonrenew a policy. (3-20-04)

03. Department. The Idaho Department of Insurance. (3-20-04)

04. Noncredit Factor. Any factor other than a credit factor that is reasonably expected to affect the risk assumed by an insurer and is used by the insurer in determining policy premium rates, or in determining whether to

issue, cancel or nonrenew a policy. (3-20-04)

05. Policy. A contract for property or casualty insurance, as defined by Chapter 5, Title 41, Idaho Code, that is purchased or maintained primarily for personal, family or household purposes. (3-20-04)

06. Weight. The consideration given by an insurer to a particular credit or noncredit factor relative to other factors considered in the underwriting or rating process. (3-20-04)

011. -- 099. (RESERVED)

100. USE OF CREDIT FACTORS.

01. Prohibited Acts. An insurer shall not charge a higher premium than would otherwise be charged, or cancel, nonrenew or decline to issue a policy, based in any part upon credit factors unless: (3-20-04)

a. The decision is also based on a noncredit factor or factors; and (3-20-04)

b. The aggregate weight given to the noncredit factors considered in making the decision is at least as great as the aggregate weight given to the credit factors considered in making the decision. (3-20-04)

02. Application of Rule. To determine whether a decision to issue, nonrenew or cancel a policy, or to charge a higher rate than would otherwise be charged, is not improperly based primarily upon a credit factor or factors and in violation of Section 41-1843, Idaho Code, the Department will apply the following criteria: (4-4-13)

a. If an insurer declines to issue, nonrenews or cancels a policy based in any part upon a credit factor, the insurer must be able to show that it also relied upon a noncredit factor or combination of noncredit factors in making the decision and that the noncredit factor(s) played at least as great a role in the decision as did the credit factor. Nothing in this rule is intended to modify or alter any provisions contained in Title 41, Chapter 25, Idaho Code. (4-4-13)

b. If an insurer relies in any part upon a credit factor in establishing an initial rate for new business or to impose an increase in premium rate for a customer, the insurer must be able to show that it also considered noncredit factors in establishing the initial rate and that not more than one-half (½) of the initial or renewal premium rate is attributable to the credit factor. To satisfy this requirement, an insurer shall do one (1) of the following: (4-4-13)

i. Compare the premium rate using the highest credit factor to the premium rate using the lowest credit factor. The difference in the premium rate between the highest and lowest shall be not more than one-half (½) the highest premium rate; or (4-4-13)

ii. Compare a premium rate calculated using the highest credit factor to a premium rate calculated without using credit. The premium rate calculated without using credit shall be equal to or greater than one-half (½) of the premium rate calculated using the highest credit factor. To calculate the premium rate without using credit, an insurer shall demonstrate that it has applied all the noncredit factors and replaced the actual credit factor with the average credit factor. The average credit factor must be calculated from the actual distribution of Idaho business by credit factor at the time the credit factor rating system was implemented or last revised. For purposes of this Subparagraph, 100.02.b.ii., "last revised" means any subsequent changes to the credit factor system utilized by the insurer as part of its overall rate filing. Under this approach, as long as the highest rate charged using a credit factor is not more than double the rate using the average credit factor, the rate will be treated as meeting the requirements of Section 41-1843, Idaho Code. (4-4-13)

03. Information Used in Reviewing Insurer's Decision. To evaluate whether an underwriting or rating decision was based primarily upon credit factors, the department may require the insurer to explain in detail the insurer's underwriting or rating process, identify all factors considered in the process, and describe how the process was applied in the case under review. The department may also require the insurer to apply its underwriting or rating process to hypothetical cases submitted to the insurer by the Department. (3-20-04)

101. -- 199. (RESERVED)

200. OTHER LAWS OR RULES.

Nothing in this rule shall be construed to limit or modify any other laws or rules imposing restrictions regarding rating, issuing, canceling or nonrenewing a policy. (3-20-04)

201. -- 299. (RESERVED)

300. TRADE SECRETS.

Any information submitted by an insurer pursuant to this rule that the insurer considers to be a trade secret as defined by Section 9-340D, Idaho Code, and not subject to public disclosure, shall be clearly identified as such at the time it is submitted to the department. (3-20-04)

301. -- 399. (RESERVED)

400. RETENTION OF RECORDS.

Insurers subject to this rule shall document the factors and criteria considered in underwriting and rating decisions and shall retain the documentation for at least five (5) years from the date of the decision. (3-20-04)

401. -- 499. (RESERVED)

500. VIOLATIONS.

A failure to comply with this rule is a violation of Section 41-1843, Idaho Code. (3-20-04)

501. -- 999. (RESERVED)

**IDAPA 18
TITLE 02
CHAPTER 02**

18.02.02 – AUTOMOBILE INSURANCE POLICIES

000. LEGAL AUTHORITY.

Title 41, Chapter 25, Idaho Code; Title 67, Chapter 52, Idaho Code. (3-1-93)

001. TITLE AND SCOPE.

01. Title. These rules are titled, IDAPA 18.02.02, “Automobile Insurance Policies.” (3-28-18)

02. Purpose. The purpose of this Rule is to provide guidelines that will assist in the implementation and uniform interpretation of the following Sections of the Idaho Code. (3-28-18)

a. Section 41-2506 - Cancellation of Policies - Definitions. (7-1-93)

b. Section 41-2507 - Cancellation of Policies - Grounds. (7-1-93)

c. Section 41-2508 - Notice of Cancellation or Intention not to Renew. (7-1-93)

d. Section 41-2509 - Cancellations and Non-Renewals - Exceptions. (7-1-93)

e. Section 41-2502 – Uninsured motorist and underinsured motorist coverage for automobile insurance – Exceptions. (3-28-18)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. (3-28-18)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General - General Provisions.” (3-28-18)

004. INCORPORATION BY REFERENCE.

No documents are incorporated in this chapter of rule. (3-28-18)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-28-18)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-28-18)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-28-18)

04. Web Address. The department’s website is <http://www.doi.idaho.gov>. (3-28-18)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code, as well as applicable exemptions. (3-28-18)

007. -- 009. (RESERVED)

010. DEFINITIONS.

The Idaho Department of Insurance adopts the definitions set forth in Title 41, Chapter 25, Idaho Code. In addition,

the following terms are defined as used in this chapter. (3-28-18)

01. The Act. For the purpose of this Rule, the term “the Act” shall, unless otherwise noted, refer to Sections 41-2506, 41-2507, 41-2508, 41-2509, 41-2510, 41-2511, 41-2512 of the Idaho Insurance Laws, otherwise known as the Insurance Code. (7-1-93)

02. Non-Payment of Premium. The provisions of Section 41-2506(1)(d), Definitions - Non-Payment of Premium, means the failure of the named insured, or his legal representative, to discharge when due any of his obligations in connection with the payment of any premiums or installment premiums on a policy as defined in the Act, or any membership fees due an association or organization, other than an insurance association or organization, which by its by-laws requires the payment of such membership fees by the member prior to his obtaining or continuing insurance in force through such an association or organization. The term “non-payment of premium” as referred to in the Act shall also apply when the named insured or his legal representative is obligated to pay such premium or membership fee directly to the insurer, its agent or representative, or indirectly under any premium finance plan or extensions of credit. However, if the agent or other representative of the insurer extends credit to the insured, orally or otherwise, and said agent or representative terminates such credit arrangement with the insured because of non-payment, said agent or representative, with the knowledge and consent of the insurer, shall then mail or deliver, or cause to be mailed or delivered, to the named insured or his legal representative written notice of cancellation which states, in effect, that the insurance provided by the policy upon which such credit was granted shall cease on a given time and date. This time and date shall be no earlier than ten (10) days after the date such notice was mailed or delivered, the date of mailing considered to be the first day and the tenth day being considered to be ended at midnight, standard time, at the last known address of the named insured. Nothing in this rule shall be construed to permit any agent or other representative of the insurer to cancel any policy without the concurrence of the insurer or for any private debt between the agent and the insured. Also, nothing in the section shall be construed to prohibit a policy from being canceled effective as of any date that is mutually acceptable to the insured, the insurer and the lienholder, if any. Furthermore, a prior existing policy shall terminate on the effective date of any other policy procured by the insured with respect to any automobile designated in both policies and containing duplicate insurance coverage. (7-1-93)

03. Sixty Day Period. The sixty (60) day period referred to in Subsection (2) of Section 41-2506, Cancellation of Policies - Definitions, is intended to provide to insurers a reasonable period of time, if desired, to thoroughly investigate a particular risk while extending coverage during the period of investigation. Should an insurer, after such investigation, conclude that it does not wish to remain on the risk, it may decline to continue such policy in force provided that its action conforms with the provisions of Section 41-2506(2) of the Act. Therefore, the provisions of this section shall be interpreted to mean that an insurer may deliver notice of cancellation or mail notice of cancellation concerning any new automobile policy on or before the sixtieth (60th) day after inception date of the policy, the inception date being considered to be the first day and the sixtieth (60th) day being considered to be ended at midnight, standard time, at the last known address of the named insured. The policy shall thus remain in force from the date the notice of cancellation is mailed to the usual date the cancellation is effective as required by the terms and conditions of the policy, without the policy being considered to be subject to the provisions of the Act. For the purpose of this rule, the term “inception date” shall mean that date and time that the policy goes into effect and the protection furnished by the policy commences. (7-1-93)

011. ERRORS OR MISREPRESENTATIONS IN THE APPLICATION.

01. Material Misrepresentation. The provisions of Section 41-2507(2), Cancellation of Policies - Grounds, relating to material misrepresentation by the insured in obtaining a policy as permitted grounds for cancellation of the policy, shall be construed to mean that an insurer may cancel or refuse to renew a policy after giving the insured proper notice if the insurer has evidence that the named insured, or his legal representative, made fraudulent or material misrepresentations, omissions, concealment of facts or incorrect statements in obtaining the policy and if the insurer in good faith would not have issued the policy nor would have provided coverage with respect to a particular hazard if the true facts had been made known to the insurer as required in the application. (7-1-93)

02. Prohibitions. Nothing in this rule shall be construed to allow the insurer to void the policy back to its inception date or rescind coverage under the policy in order to prevent a recovery under the policy in the event of a loss otherwise insured by the policy. (7-1-93)

03. Representations -- Application. Nothing in this rule shall be construed to change the meaning of, or modify in any way, Section 41-1811, Representations in Application, Idaho Code. (7-1-93)

012. ALLOWABLE CONVICTIONS FOR TRAFFIC VIOLATIONS.

01. Grounds and Requests for Cancellation Due to Traffic Violation Convictions. Section 41-2507(7)(h), Cancellation of Policies -- Grounds, shall be construed to mean that an insurer may send proper notice of cancellation as soon as the named insured has been convicted of or forfeited bail for three (3) or more violations, as described under this section, within the thirty-six (36) months immediately preceding the notice of cancellation or non-renewal. The insurer may also send proper notice of cancellation at such time as any other individual operator who either resides in the same household or customarily operates an automobile insured under the policy has been convicted of or forfeited bail for three (3) or more violations as described under this section within the thirty-six (36) months immediately preceding the notice of cancellation or non-renewal. (7-1-93)

02. Conviction. For the purposes of the Act, the term "conviction" shall mean a final conviction by any court having competent jurisdiction over violations of laws regulating the operation of motor vehicles as set out in Section 41-2507(7)(h), Idaho Code. (7-1-93)

03. Conviction Exception. For the purposes of the Act, a conviction for an overtime parking violation is not a conviction that would provide a valid reason for an insurer to send notice of cancellation of or refusal to renew a policy. (7-1-93)

013. NOTICE OF PREMIUM DUE AS WILLINGNESS OF INSURER TO RENEW.

01. Policy Renewal, Nonrenewal Requests. Some insurers effect a renewal of their outstanding policies of automobile insurance merely by sending a renewal premium notice to the insured a reasonable period of time in advance of the expiration date of his policy. The insured need only make a timely payment of the premium due in order to keep his policy in force. In this situation, the mailing by the insurer of the renewal premium notice does constitute such a manifestation of willingness by the insurer to renew as to comply with Section 41-2508(2) of the Act. If the insured fails to pay the renewal premium when due, the policy will terminate in accordance with its terms. No further notice to the insured by the insurer of an intention not to renew for non-payment of premium is necessary. (7-1-93)

02. Renewal. Inasmuch as Section 41-2508(2) of the Act, entitled, Notice of Cancellation or Intention Not To Renew, requires in effect that no insurer shall fail to renew a policy to which Section 41-2506 of the Act applies unless the insurer has manifested its willingness to renew, it might be implied that the insurer must automatically renew the policy whether or not requested to do so by the named insured or his agent. It is the position of the Department of Insurance that such an implication was not intended in the Act and, therefore, failure to send notice to the insured of the insurer's intent not to renew a policy shall also be considered to be a manifestation by the insurer of its willingness to renew the policy, and nothing in this subsection requires an insurer to renew a policy unless requested to do so by either the insured or his agent. Nevertheless, if an agent, who is properly licensed to represent the insurer, asks the insurer not to renew a particular policy and the insurer complies with this request, then such failure to renew the policy constitutes a "Refusal to Renew" under the provisions of the Act. In the event the policy in question does not have a fixed and definite expiration date, the insurer, or its authorized legal representative, shall be required to send proper notice of premium due to the insured's last known mailing address not less than fifteen (15) days prior to the date the policy would expire in the event such premium was not paid and such notice of premium due shall plainly indicate the date that coverage ceases under the policy because of non-payment of premium. On policies that do contain a fixed and definite renewal date, proper notice of the forthcoming expiration date and the premium due shall be sent to the last known address of the named insured by the insurer or its authorized legal representative at least fifteen (15) days prior to said expiration date. (7-1-93)

014. AGENT SHALL NOT WITHHOLD BENEFITS OF THIS ACT FROM THE INSURER.

01. Penalties. Any insurance agent or other representative of an insurer who knowingly or willfully withholds information or gives misleading information, or in any manner conceals from the insured knowledge to the effect that the insurer under the new policy may not be subject to the obligations and responsibilities intended by the

Act for the first sixty (60) day period as provided by Section 41-2506(2) of the Act, shall be subject to the penalties prescribed or referred to in Section 41-117, General Penalty, for violation of Section 41-1305, Twisting, Prohibited, Idaho Code. (7-1-93)

015. ACCEPTABLE FORMS FOR NOTICE OF CANCELLATION, REFUSAL TO RENEW, AND AVAILABILITY OF IDAHO AUTOMOBILE INSURANCE PLAN.

01. Notice Forms. Each insurer shall prepare the forms of notice which it proposes to use and submit such to the Director of Insurance for approval. (7-1-93)

02. Acceptable Language. As a guide, the Department will accept the following language, or language substantially similar, as satisfying the indicated notice requirements of the Act: (7-1-93)

a. Right of Insured to Request Reasons for Cancellation by Insurer: “As required by State Insurance Laws, upon your written request, mailed or delivered to (Name of Insurer) not less than ten (10) days prior to the effective date of this cancellation, (Name of Insurer) will supply to you the reason or reasons why your policy has been canceled.” (7-1-93)

b. Right of Insured to Request Reasons for Refusal to Renew by Insurer: “As required by State Insurance Laws, upon your written request, mailed or delivered to (Name of Insurer) not less than fifteen (15) days prior to the expiration date of your policy, which is the date coverage ceases under your policy unless it is renewed, the (Name of Insurer) will supply to you the reason or reasons why your policy will not be renewed.” (7-1-93)

c. Notification to Insured of Coverage Available Under Idaho Automobile Insurance Plan: “Should you experience difficulty in obtaining automobile liability insurance, please contact your agent or company representative for full particulars concerning your possible eligibility for insurance through the Idaho Automobile Insurance Plan.” (7-1-93)

016. STANDARD STATEMENT REGARDING UNINSURED AND UNDERINSURED MOTORIST COVERAGE.

The form set forth below is the standard statement approved by the director of the department of insurance pursuant to Section 41-2502, Idaho Code, and carriers must begin using the new form for all new policies and those existing policies where UM or UIM coverage is added or removed no later than January 1, 2019. Carriers may make non-substantive changes to this form, for example, including inserting company letterhead, and carriers must file their standard statement forms with the director prior to use. This rule does not create new requirements for the types of UIM coverage carriers must offer beyond what existed as of the effective date of this rulemaking. (3-28-18)

017. -- 999. (RESERVED)

APPENDIX A
(UNINSURED/UNDERINSURED MOTORIST DISCLOSURE)

IDAHO UNINSURED MOTORIST AND UNDERINSURED MOTORIST DISCLOSURE -- Do not sign until you read

Idaho law requires that every auto liability insurance policy include **Uninsured Motorist (UM)** bodily injury coverage and **Underinsured Motorist (UIM)** bodily injury coverage, unless a named insured (you) has rejected these coverages in writing, which may be in electronic format.

These coverages can protect you and your passengers by paying damages, up to the UM/UIM policy limits you have chosen, when an at-fault person does not have any or enough liability coverage.

- **UM** coverage may pay damages for bodily injuries caused by an at-fault motorist who has no insurance, or from a hit-and-run vehicle where the at-fault party is unknown.
- **UIM** coverage may pay damages for bodily injuries if the at-fault motorist does not have enough liability insurance to cover your costs. UIM coverage is offered in different types by different insurers, and insurers are not required to offer more than one type of UIM coverage. The most common available type of UIM coverage is "Difference in Limits" (or "Offset") Coverage. Some insurers may offer "Excess" Coverage. **Please refer to the attached examples to see how the different types of UIM coverage may impact your level of protection.**

You have the option to purchase both UIM and UM coverage in varying amounts at or above the minimum liability requirements in Idaho, which are \$25,000 per person, \$50,000 for two or more persons in any one accident. By signing below, you acknowledge that the insurance company has explained the following UM/UIM coverages that are available as part of your policy:

Insurer: _____ UIM Type: Difference in Limits (Offset) Excess

I have read the above explanation of Uninsured Motorist and Underinsured Motorist coverages. I understand that I have the option to reject either or both coverages.

Named Insured (print name) **Signature of Named Insured** **Date**

UNINSURED AND UNDERINSURED MOTORIST COVERAGE – OPTION TO REJECT

I understand that, by signing below, I am informing my insurer that I choose to reject the UM/UIM coverage(s) under my automobile liability policy, or under any renewal or replacement of my policy.

I **reject** and **do not** wish to purchase *Uninsured Motorist Coverage (UM)*.

Signature of Named Insured (only if rejecting) **Date**

I **reject** and **do not** wish to purchase *Underinsured Motorist Coverage (UIM)*.

Signature of Named Insured (only if rejecting) **Date**

This general explanation is NOT an insurance agreement. All auto insurance policies have terms and conditions that control your rights and obligations as a policyholder. For a more detailed explanation of these coverages, refer to your policy, agent or the insurer. The Idaho Department of Insurance can also provide assistance with insurance related questions. Call 800-721-3272 (Idaho only) or 208-334-4250 or visit the Department's website at www.doi.idaho.gov.

	"Difference in Limits" (or "Offset") UIM	"Excess" UIM
Definition of the type of UIM coverage	Your UIM coverage limits are reduced or eliminated by any amounts recovered from another party's insurance.	Your UIM coverage limits are above and beyond what is paid by another party's insurance.

Example 1		
At-fault motorist and you have the same bodily injury/UIM coverage limits		
	"Difference in Limits" (or "Offset") UIM	"Excess" UIM
Bodily Injury liability limit of at-fault motorist	\$25,000	\$25,000
Your Underinsured Motorist (UIM) Coverage limit	\$25,000	\$25,000
Maximum available for your bodily injury	\$25,000	\$50,000
Example 1 explanation	Your UIM coverage doesn't provide additional coverage above the at-fault motorist's coverage because they have the same limit	Your UIM coverage increases the available Bodily Injury coverage above the at-fault motorist's coverage limit

Example 2		
At-fault motorist has lower bodily injury coverage limits than your UIM		
	"Difference in Limits" (or "Offset") UIM	"Excess" UIM
Bodily Injury Liability limit of at-fault motorist	\$25,000	\$25,000
Your Underinsured Motorist (UIM) Coverage limit	\$100,000	\$100,000
Maximum available for your bodily injury	\$100,000	\$125,000
Example 2 explanation	Your UIM coverage covers any deficiency in the at-fault motorist's Bodily Injury coverage, as if the at-fault motorist had Bodily Injury coverage at your UIM limit	Your UIM coverage increases the available Bodily Injury coverage above the at-fault motorist's coverage limit

**IDAPA 18
TITLE 02
CHAPTER 03**

18.02.03 – CERTIFICATE OF LIABILITY INSURANCE FOR MOTOR VEHICLES

000. LEGAL AUTHORITY.

The statutory authority for this rule is Title 67, Chapter 52, and Sections 49-1229, 49-1231, and 49-1608A, Idaho Code. (3-30-07)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.02.03, “Certificate of Liability Insurance for Motor Vehicles.” (3-30-07)

02. Scope. These rules identify requirements for a certificate of liability insurance for motor vehicles pursuant to Sections 49-1229, 49-1331 and 49-1608A, Idaho Code. (3-30-07)

002. WRITTEN INTERPRETATIONS.

This agency does not rely on written interpretations for these rules. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-30-07)

004. INCORPORATION BY REFERENCE.

There are no documents incorporated by reference. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)

04. Web Site Address. The department’s website is <https://doi.idaho.gov>. (5-3-03)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho. (3-30-07)

007. -- 010. (RESERVED)

011. CONTRACT OF INSURANCE, OR COPY THEREOF -- CERTIFICATE OF LIABILITY INSURANCE.

The original contract of liability insurance, or copy thereof, that demonstrates the current existence of liability insurance against loss resulting from liability imposed by law for bodily injury or death or damage to property suffered by any person caused by accident and arising out of the operation, maintenance or use of a motor vehicle or motor vehicles described therein in an amount not less than that required by Sections 49-117(18), 49-1212, and 49-1608A, Idaho Code, and also demonstrates the current existence of any other coverage required by Title 41, Idaho Code, is a form of a certificate of liability insurance prescribed as such by the Director of the Department of Insurance, provided said contract of liability insurance is issued by an insurer or surety authorized to do business in this state. For the purpose of this rule a written binder qualifies as a contract of liability insurance provided that it binds coverage in an amount not less than that required by Section 49-117(18), Idaho Code, and demonstrates the existence of any other coverage required by this rule. (6-30-19)T

012. MINIMUM SPECIFICATIONS FOR A CERTIFICATE OF LIABILITY INSURANCE IN LIEU OF THE CONTRACT OF INSURANCE, OR COPY THEREOF.

A document that meets the minimum specifications provided in this rule is deemed to be a certificate of liability insurance in a form prescribed by the Director of the Department of Insurance, which is acceptable in lieu of an original contract of liability insurance or copy thereof, demonstrating the current existence of liability insurance as described in Section 011 of this rule. The minimum requirement of a document that will be deemed a certificate of liability insurance in lieu of the original contract of liability insurance, or copy thereof, are as follows: (3-30-07)

01. Individual-Owned Motor Vehicles. (3-30-07)

a. Name of Insurer. The document shall contain the name of the insurer or surety company authorized to do business in this state. (7-1-93)

b. Name and Address of Motor Vehicle Owner. The document shall set forth the name and address of the owner of the motor vehicle that is insured. (7-1-93)

c. Description of Motor Vehicles. The document shall set forth a description of the motor vehicle including identification number, if there be one, or in lieu of the identification number, the last three digits of the identification number, which is commonly known in the insurance industry as the VIN (Vehicle Identification Number), if there be one vehicle, or in lieu of the vehicle identification number, the words "all owned vehicles" may be used if more than one vehicle is insured. (7-1-93)

d. Effective Date. The document shall set forth the effective date the liability insurance coverage commences. (7-1-93)

e. Title of Document. The document may, but is not required to be entitled "Certificate of Liability Insurance" or "Liability Insurance Identification Card." The words "State of Idaho" may be added to the title at the insurer's option, but the words "State of Idaho" are not required. (7-1-93)

f. Date Coverage Ceases. The document may set forth the date the liability insurance coverage ceases, or in lieu thereof and at the insurer's option, the document may state "not valid beyond _____," provided that the phrase is completed to indicate termination of coverage at the end of a fixed period, or "not valid for more than one year," or "continuous until cancelled." (7-1-93)

g. Policy Number. The number of the insurance policy or the document is suggested, but is nevertheless optional and need not be placed on the document. (7-1-93)

h. Suggested Language. The sentence "KEEP THIS CERTIFICATE IN YOUR AUTOMOBILE AT ALL TIMES" is suggested, but nevertheless is optional and need not be placed on the document. (7-1-93)

02. Dealer and Manufacturer Vehicles. (3-30-07)

a. Name of Insurer. The document shall contain the name of the insurer or surety company authorized to do business in this state. (3-30-07)

b. Name and Address of Dealer or Manufacturer. The document shall set forth the name and address of the dealership and identify the owner(s) (name of dealer, partners, corporation or LLC members) of the motor vehicle that is insured. (3-30-07)

c. Effective Date. The document shall set forth the effective date the liability insurance coverage commences. (3-30-07)

d. Title of Document. The document may, but is not required to be entitled "Certificate of Liability Insurance" or "Liability Insurance Identification Card." The words "State of Idaho" may be added to the title at the insurer's option, but the words "State of Idaho" are not required. (3-30-07)

e. Date Coverage Ceases. The document may set forth the date the liability insurance coverage

ceases, or in lieu thereof and at the insurer's option, the document may state "not valid beyond _____," provided that the phrase is completed to indicate termination of coverage at the end of a fixed period, or "not valid for more than one year," or "continuous until cancelled." (3-30-07)

f. Policy Number. The number of the insurance policy or the document is suggested, but is nevertheless optional and need not be placed on the document. (3-30-07)

013. EXAMPLE OF A NONEXCLUSIVE FORMAT FOR A DOCUMENT THAT MEETS THE REQUIREMENTS OF A CERTIFICATE OF LIABILITY INSURANCE IN A FORM PRESCRIBED BY THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.

01. Exhibit A. Exhibit "A" to this rule is a format for a document that meets the requirements of a certificate of liability insurance as required by Section 49-1231, Idaho Code, in a form prescribed by the Director of the Department of Insurance; provided, however, that the following form is not exclusive, and other formats for documents that meet the minimum specifications provided in Section 012 of this rule are also deemed to qualify as a certificate of liability insurance in a form prescribed by the Director of the Department of Insurance. (3-30-07)

02. Exhibit B. Exhibit "B" to this rule is a format for a document that meets the requirements of a certificate of liability insurance for dealers and vehicle manufacturers as required by Section 49-1608A, Idaho Code, in a form prescribed by the Director of the Department of Insurance; provided, however, that the following form is not exclusive, and other formats for documents that meet the minimum specifications provided in Section 012 of this rule are also deemed to qualify as a certificate of liability insurance in a form prescribed by the Director of the Department of Insurance. (3-30-07)

014. EXAMPLE OF CERTIFICATE OF LIABILITY INSURANCE TO BE ISSUED BY THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.

The Director of the Department of Insurance will issue a certificate of liability insurance to the owner(s) of a motor vehicle who posts an indemnity bond in a form approved by the Director of the Department of Insurance, pursuant to Section 49-1229(2), Idaho Code in an amount of not less than fifty thousand dollars (\$50,000) for any one (1) accident of which fifteen thousand dollars (\$15,000) shall be for property damage for each vehicle registered up to a maximum of one hundred twenty thousand dollars (\$120,000) for five (5) or more vehicles. Exhibit "C" to this rule reflects the format for a certificate of liability insurance to be issued by the Director of the Department of Insurance when an indemnity bond is posted with the Department pursuant to Section 49-1229(2), Idaho Code, in lieu of purchasing a policy of insurance. (3-30-07)

015. -- 999. (RESERVED)

**EXHIBIT "A"
DEPARTMENT RULE NO. 34
(FRONT SIDE)**

(STATE)

	INSURANCE IDENTIFICATION CARD	
COMPANY NUMBER	COMPANY	
POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE
YEAR	MAKE/MODEL	VEHICLE IDENTIFICATION NUMBER
AGENCY/COMPANY ISSUING CARD		
INSURED		

(
(
SEE IMPORTANT NOTICE ON REVERSE SIDE
(REVERSE SIDE)

THIS CARD MUST BE KEPT IN THE INSURED
VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to you Agency/Company as soon as possible. Obtain the following information:

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number of each vehicle involved.

EXHIBIT "B"
DEPARTMENTAL RULE NO. 34
CERTIFICATE OF LIABILITY INSURANCE

DEALER AND VEHICLE MANUFACTURER

TO BE COMPLETED BY INSURANCE COMPANY LICENSED TO DO
BUSINESS IN THE STATE OF IDAHO

EFFECTIVE DATE	EXPIRATION DATE	INSURANCE COMPANY NAME (NOT AGENT)	
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

THIS POLICY IS ISSUED TO (NAME OF DEALER, PARTNERS, CORPORATION OR LLC NAME.)

BUSINESS NAME OF DEALER/MANUFACTURER: _____

BUSINESS ADDRESS _____

DEALER NUMBER _____

CERTIFY THAT THE FOLLOWING IS TRUE AND CORRECT

The above described policy has been issued and provides limits of coverage required under Section 49-1608A, Idaho Code; covers all vehicles manufactured, owned, operated, used or maintained by, or under the control of the named insured; covers all persons who, with the consent of the named insured, use or operate vehicles manufactured, owned or maintained by, or under the control of, the named insured.

PRINTED NAME OF INSURER'S AUTHORIZED REPRESENTATIVE	TELEPHONE NO.	DATE
---	---------------	------

SIGNATURE OF INSURER'S AUTHORIZED REPRESENTATIVE

INSURER'S STAMP OR SEAL

EXHIBIT "C"
DEPARTMENTAL RULE NO. 34
CERTIFICATE OF LIABILITY INSURANCE

(Name and Address of Owner(s) of Registered Motor Vehicles):

(Name) (Address)

(Name) (Address)

(Name) (Address)

The above-named owner(s) of the following described motor vehicle(s) with identification number(s):

in lieu of obtaining a policy of liability insurance has posted bond pursuant to Section 49-1229(2), Idaho Code, in a form approved by the Director of the Department of Insurance:

(Surety) _____

Bond No. _____

Bond Amount _____

Effective Date: _____

Expiration Date: _____

DATED this _____ day of _____, 20.

(SEAL)

Director,

Department of Insurance

**IDAPA 18
TITLE 03
CHAPTER 01**

18.03.01 – SUITABILITY IN ANNUITY TRANSACTIONS

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to authority granted by Sections 41-211 and 41-1940, Idaho Code. (4-4-13)

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.03.01, "Suitability in Annuity Transactions." (4-4-13)

02. Scope. This rule applies to any recommendation to purchase or exchange an annuity made to a consumer by a producer, or an insurer where no producer is involved, that results in the purchase or exchange recommended. (4-4-13)

002. PURPOSE.

01. Purpose. The purpose of this rule is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed. (4-4-13)

02. Violation of Rule. Nothing herein is construed to create or imply a private cause of action for a violation of this rule. (4-4-13)

003. WRITTEN INTERPRETATIONS.

There are no written interpretations for these rules. (4-4-13)

004. ADMINISTRATIVE APPEALS.

All administrative appeals are governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," Subchapter B -- Contested Cases. (4-4-13)

005. INCORPORATION BY REFERENCE.

01. Incorporated Documents. IDAPA 18.03.01, "Suitability in Annuity Transactions," adopts and incorporates by reference parts of the following documents: (4-4-13)

a. United States Code, Title 29 - Labor, Chapter 18 - Employee Retirement and Income Security Act (ERISA). (4-4-13)

b. United States Code, Title 26 - Internal Revenue Code. (4-4-13)

c. FINRA Rule 2111, effective July 9, 2012. (4-4-13)

02. Availability of Referenced Documents. (4-4-13)

a. Printed copies of the documents described in Subsections 005.01.a. and 005.01.b. are available from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 as well as from the Department; the telephone number is (202) 512-1800, and electronic copies are available online at <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title29/pdf/USCODE-2011-title29-chap18.pdf> and <http://www.law.cornell.edu/uscode/text/26>. (4-4-13)

b. A printed copy of the document described in 005.01.c. is available from FINRA, Two Union Square, 601 Union Street, Suite 1616, Seattle, WA 98101-2327, telephone (206) 624-0790, as well as from the Department, and an electronic copy is available online at <http://finra.complinet.com/en/display/>

[display_main.html?rbid=2403&element_id=9859.](#) (4-4-13)

006. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB ADDRESS.

- 01. Office Hours.** 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-4-13)
- 02. Mailing Address.** P.O. Box 83720, Boise, ID 83720-0043. (4-4-13)
- 03. Street Address.** 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (4-4-13)
- 04. Web Site Address.** The department’s website is <http://www.doi.idaho.gov>. (4-4-13)

007. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-4-13)

008. -- 009. (RESERVED)

010. DEFINITIONS.

01. Annuity. An annuity that is an insurance product under State law that is individually solicited, whether the product is classified as an individual or group annuity. (4-4-13)

02. Continuing Education Credit or CE Credit. One continuing education credit as more particularly described in IDAPA 18.06.04, “Continuing Education”. (4-4-13)

03. Continuing Education Provider or CE Provider. An individual or entity that is approved to offer continuing education courses pursuant to IDAPA 18.06.04, “Continuing Education”. (4-4-13)

04. FINRA. The Financial Industry Regulatory Authority or a succeeding agency. (4-4-13)

05. Insurer. A company required to be licensed under the laws of this state to provide insurance products, including annuities. (4-4-13)

06. Producer. A person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities. (4-4-13)

07. Recommendation. Advice provided by a producer or an insurer to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice. (4-4-13)

08. Replacement. A transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer or to proposing insurer that by reason of the transaction, an existing policy or contract has been or is to be: (4-4-13)

a. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated; (4-4-13)

b. 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; (4-4-13)

c. 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; (4-4-13)

d. Reissued with any reduction in cash value; or (4-4-13)

e. Used in a financed purchase. (4-4-13)

09. Suitability Information. Information that is reasonably appropriate to determine the suitability of a recommendation, including the following: (4-4-13)

- a.** Age; (4-4-13)
- b.** Annual income; (4-4-13)
- c.** Financial situation and needs, including the financial resources used for the funding of the annuity; (4-4-13)
- d.** Financial experience; (4-4-13)
- e.** Financial objectives; (4-4-13)
- f.** Intended use of the annuity; (4-4-13)
- g.** Financial time horizon; (4-4-13)
- h.** Existing assets, including investment and life insurance holdings; (4-4-13)
- i.** Liquidity needs; (4-4-13)
- j.** Liquid net worth; (4-4-13)
- k.** Risk tolerance; and (4-4-13)
- l.** Tax status. (4-4-13)

011. TRANSACTION EXEMPTIONS.

Unless otherwise specifically included, this rule does not apply to transactions involving: (4-4-13)

01. Direct Response Solicitations. A response to a direct solicitation where there is no recommendation made based on information collected from the consumer pursuant to this rule; (4-4-13)

02. Contracts Used to Fund. Contracts that are used to fund: (4-4-13)

a. An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA); (4-4-13)

b. A plan described by Sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer; (4-4-13)

c. A government or church plan defined in Section 414 of the IRC, as amended, 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, as amended; (4-4-13)

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; (4-4-13)

e. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; (4-4-13)

f. Formal prepaid funeral contracts; or (4-4-13)

g. Prepaid contracts used to fund funeral and related funeral expenses governed by Sections 54-1131 et seq., Idaho Code. (4-4-13)

012. -- 014. (RESERVED)

015. DUTIES OF INSURERS AND OF PRODUCERS.

01. General Rule. In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the producer or insurer must have a reasonable basis to believe that the recommendation is suitable for the consumer based on the facts disclosed by the consumer. These facts include the consumer's suitability information and information regarding the consumer's investments and other insurance products, and financial situation and needs. The seller must also have a reasonable basis to believe all of the following: (4-4-13)

- a.** The consumer has been reasonably informed of various features of the annuity, including: (4-4-13)
 - i.** The potential surrender period and surrender charge; (4-4-13)
 - ii.** The potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; (4-4-13)
 - iii.** Mortality and expense fees; (4-4-13)
 - iv.** Investment advisory fees; (4-4-13)
 - v.** Potential charges for and features of riders; (4-4-13)
 - vi.** Limitations on interest returns; (4-4-13)
 - vii.** Insurance and investment components; and (4-4-13)
 - viii.** Market risk; (4-4-13)
- b.** The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, or death or living benefit; (4-4-13)
- c.** The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable for the particular consumer based on his suitability information; and (4-4-13)
- d.** In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable and the producer or insurer has considered whether the consumer: (4-4-13)
 - i.** Will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements; or (4-4-13)
 - ii.** Would benefit from product enhancements and improvements; or (4-4-13)
 - iii.** Has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding thirty-six (36) months. (4-4-13)

02. Collection of Information. Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, a producer, or insurer when no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information. (4-4-13)

03. Reasonable Basis. Except as permitted under Subsection 015.04, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information. (4-4-13)

- 04. Exceptions.** (4-4-13)
- a.** Except as provided under Paragraph 015.04.b., neither a producer nor an insurer shall have any obligation to a consumer under Subsection 015.01 or 015.03 related to any annuity transaction if: (4-4-13)
- i.** No recommendation is made; or (4-4-13)
- ii.** A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer; or (4-4-13)
- iii.** A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or (4-4-13)
- iv.** A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the producer. (4-4-13)
- b.** An insurer's issuance of an annuity subject to Paragraph 015.04.a. will be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued. (4-4-13)
- 05. Record Keeping.** A producer or, when no producer is involved, the responsible insurer representative, shall at the time of sale: (4-4-13)
- a.** Make a record of any recommendation subject to Subsection 015.01; (4-4-13)
- b.** Obtain a customer signed statement documenting a customer's refusal to provide suitability information, if any; and (4-4-13)
- c.** Obtain a customer signed statement that acknowledges that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's or insurer's recommendation. (4-4-13)
- 06. Supervision for Compliance.** (4-4-13)
- a.** An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with this rule. This includes, but is not limited to, the following: (4-4-13)
- i.** Establishing and maintaining reasonable procedures to inform its producers of the requirements of this rule and incorporating the requirements of this rule into relevant producer training manuals; (4-4-13)
- ii.** Establishing standards for producer product training and establishing and maintaining reasonable procedures to require its producers to comply with the requirements of Section 016 of this rule; (4-4-13)
- iii.** Providing product-specific training and training materials that explain all material features of its annuity products to its producers; (4-4-13)
- iv.** Establishing and maintaining procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria; (4-4-13)
- v.** Establishing and maintaining procedures to detect recommendations that are not suitable. These procedures may include confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters; or programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this rule by applying sampling procedures, or by confirming suitability information after issuance or

delivery of the annuity; and (4-4-13)

vi. Annually providing a report to senior management, including those responsible for audit functions, that details a review, with appropriate testing designed to determine the effectiveness of the supervision system, and includes any exceptions found and any corrective actions taken or recommended. (4-4-13)

b. Contracting. (4-4-13)

i. Nothing in this subsection restricts an insurer from contracting for performance of a function (including establishing and maintaining procedures) required under Paragraph 015.06.a. of this rule. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to Section 025 of this rule regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with Subparagraph 015.06.a.ii.(2) of this rule. (4-4-13)

ii. An insurer's supervision system under Paragraph 015.01.a. of this rule must include supervision of contractual performance under Subsection 015.06. This supervision of performance includes, but is not limited to, the following: (4-4-13)

(1) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and (4-4-13)

(2) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed. (4-4-13)

c. An insurer is not required to include in its system of supervision a producer's recommendations to consumers of products other than the annuities offered by the insurer. (4-4-13)

07. Prohibitions. A producer may not dissuade, or attempt to dissuade, a consumer from: (4-4-13)

a. Truthfully responding to an insurer's request for confirmation of suitability information; (4-4-13)

b. Filing a complaint; or (4-4-13)

c. Cooperating with the investigation of a complaint. (4-4-13)

08. Compliance With FINRA. (4-4-13)

a. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions as reflected in FINRA Rule 2111 will satisfy the requirements under this rule. This subsection applies to FINRA broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection limits the Director's ability to enforce the provisions of this rule or investigate for compliance. (4-4-13)

b. For Paragraph 015.08.a. to apply, an insurer must: (4-4-13)

i. Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and (4-4-13)

ii. Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system. (4-4-13)

016. PRODUCER TRAINING.

01. General Rule. A producer shall not solicit the sale of an annuity product unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with the insurer's standards for product training. A producer may rely on insurer-provided, product-specific training standards and

materials to comply with this subsection. (4-4-13)

02. Required Producer Training Courses and Education. (4-4-13)

a. A producer who engages in the sale of annuity products shall complete a one-time, four-credit training course approved by the Department and provided by the Department-approved education provider. (4-4-13)

b. Producers who hold a life insurance line of authority on the effective date of this rule and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this rule. Individuals who obtain a life insurance line of authority on or after the effective date of this rule may not engage in the sale of annuities until the annuity training course required under this subsection has been completed. (4-4-13)

c. The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credits, but may be longer. (4-4-13)

d. The training required under this subsection shall include information on the following topics: (4-4-13)

i. The types of annuities and various classifications of annuities; (4-4-13)

ii. Identification of the parties to an annuity; (4-4-13)

iii. How fixed, variable and indexed annuity contract provisions affect consumers; (4-4-13)

iv. The application of income taxation of qualified and non-qualified annuities; (4-4-13)

v. The primary uses of annuities; and (4-4-13)

vi. Appropriate sales practices, replacement and disclosure requirements. (4-4-13)

e. Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline. (4-4-13)

f. A provider of an annuity training course intended to comply with this subsection shall register as a CE provider in this State and comply with the rules and guidelines applicable to producer continuing education courses as set forth in IDAPA 18.01.53. (4-4-13)

g. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with IDAPA 18.06.04. (4-4-13)

h. Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with IDAPA 18.06.04. (4-4-13)

i. The satisfaction of the training requirements of another State that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this State. (4-4-13)

j. An insurer shall verify that a producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by Department-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers. (4-4-13)

017. -- 020. (RESERVED)

021. RECORDKEEPING.

01. Maintaining Records. Insurers and producers must maintain, and be able to provide to the Director, records of all information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for as long as the insurance transaction remains in force. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer. (4-4-13)

02. Termination. If the producer's appointment with the insurer is terminated or his license is suspended or revoked, the producer must remit copies of all records as described under Subsection 021.01 to the insurer within twenty-one (21) days of termination or change in license status. (4-4-13)

03. Form. Records required to be maintained by this rule may be maintained on any media and by any process that accurately reproduces the original document. (4-4-13)

022. -- 024. (RESERVED)

025. COMPLIANCE MITIGATION - VIOLATIONS - PENALTIES.

01. Corrective Action. An insurer is responsible for compliance with this rule. If a violation occurs, either because of the action or inaction of the insurer or its producer, the Director may order: (4-4-13)

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's or producer's violation of this rule; (4-4-13)

b. A general agency, independent agency or the producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of this rule; and (4-4-13)

c. Appropriate penalties and sanctions. (4-4-13)

02. Violation. Any violation of this rule will be deemed a violation of Section 41-1940, Idaho Code. (4-4-13)

03. Reduction of Penalty. Any applicable penalty under Section 41-117, Idaho Code, for a violation of this rule may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice. (4-4-13)

026. -- 999. (RESERVED)

**IDAPA 18
TITLE 03
CHAPTER 02**

18.03.02 – LIFE SETTLEMENTS

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the director under Sections 41-211 and 41-1965, Idaho Code. (3-29-10)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.03.02, “Life Settlements.” (3-29-10)

02. Scope. This rule sets forth requirements regarding the sale and settlement of life insurance contracts where the owner of the contract is an Idaho resident. (3-29-10)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (3-29-10)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, Idaho Rules of Administrative Procedure of the Attorney General - General Provisions. (3-29-10)

004. INCORPORATION BY REFERENCE.

No documents are incorporated by reference. (3-29-10)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-29-10)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-29-10)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (3-29-10)

04. Web Site Address. The department’s website is <https://doi.idaho.gov>. (3-29-10)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-29-10)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Advertising Materials. (3-29-10)

a. Printed and published material, audio visual material, and descriptive literature of a broker or provider used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other internet displays or communications, other forms of electronic communications, billboards and similar displays; (3-29-10)

b. Descriptive literature and sales aids of all kinds issued by a provider 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 (3-29-10)

c. Prepared sales talks, presentations and material for use by providers and brokers. (3-29-10)

02. Affiliation. For purposes of this rule and the Life Settlements Act, an affiliation shall include any contractual relationship outside of the proposed life settlement contract, any ownership interest or relation, any familial relation, an employment relation, any relationship creating financial dependency, any arrangement that provides one party the ability to control or influence the actions of another party, or any other arrangement or relationship that might reasonably result in parties treating one another in a less than arm's length manner. (3-29-10)

03. Broker. A life settlement broker as defined at section 41-1951(6), Idaho Code. (3-29-10)

04. Operating as a Broker. A person is operating as a broker if the person, for a fee, commission or other valuable consideration, offers or attempts to negotiate a life settlement contract between an owner who is a resident of Idaho and one or more providers. A person working on behalf of a broker by offering or attempting to negotiate a life settlement contract for a fee, commission or other valuable consideration is operating as a broker regardless of whether the person has a direct contractual relationship with the owner. (3-29-10)

05. Operating as a Provider. A person is operating as a provider if the person offers to enter into or attempts to effectuate a life settlement contract with an owner who is a resident of Idaho. A person attempting to effectuate a life settlement contract on behalf of a provider is also operating as a provider regardless of whether the person will be a party to the life settlement contract. (3-29-10)

06. Owner. A life insurance owner or certificate holder as defined at section 41-1951(9), Idaho Code. (3-29-10)

07. Provider. A life settlement provider as defined at section 41-1951(8), Idaho Code. (3-29-10)

011. REGISTRATION REQUIRED TO OPERATE AS LIFE SETTLEMENT PROVIDER OR LIFE SETTLEMENT BROKER.

01. Registration Required. Not later than ten (10) days after first operating as a provider or broker a person shall notify the Director that he is acting as a provider or broker by registering with the Department and paying applicable fees as set forth at IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges". Registration shall be in writing and in the form and include information as required by the Director along with a certification from the applicant that he has read and familiarized himself with the requirements of Sections 41-1950 through 41-1965, Idaho Code, and these rules. (3-29-10)

02. Renewal of Registration. Registration as a broker or provider shall continue until the next renewal date of the person's producer license. If the initial registration takes place within ninety (90) calendar days from the producer license expiration date, registration shall continue until the following producer license renewal date. Registration may be renewed by payment of the applicable renewal fee as set forth at IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges". An insurance producer who allows his registration as a broker or provider to lapse may, within twelve (12) months from the renewal due date, reinstate the registration by paying a penalty in the amount of double the unpaid renewal fee. If a registration is allowed to lapse for more than twelve (12) months without reinstatement, a producer wishing to act a broker or provider shall re-register with the Department and pay the applicable registration fee prior to operating as a broker or provider. (3-29-10)

012. FILING OF FORMS.

01. Filing of Life Settlement Contracts and Disclosure Forms. No person shall use a life settlement contract or disclosure form in Idaho unless the form is first filed with the Department along with a certification that the form meets the requirements of Sections 41-1950 through 41-1965, Idaho Code. The certification shall be in the form as prescribed by the Director and signed by a person registered as a provider or broker. (3-29-10)

02. Filing of Advertising Materials. No person shall use advertising materials promoting or advertising the availability of life settlements or life settlement services in Idaho unless the materials are first filed with the Department. If the advertising is not in written form, a written script shall be filed. All advertising relating to the business of life settlements shall have a unique identifying form number in the lower left hand corner of the advertising piece and shall comply the following standards: (3-29-10)

a. Be truthful and not misleading in fact and implication. All information shall be set out conspicuously and in close conjunction with the statements 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. (3-29-10)

b. Reference the complete form number of any life settlement contract being advertised and clearly identify the full and complete name of the provider or broker using the promotional material. Advertising materials shall not use a trade name, any insurance group designation, name of the parent company of the provider or broker, name of a particular division of the provider or broker, service mark, slogan, symbol or other device which would have the capacity and tendency to mislead or deceive as to the true identity of the provider or broker without disclosing the name of the actual provider or broker using the advertising material. (3-29-10)

c. 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 sellers or prospective sellers as to the nature or extent of any policy benefit payable. The fact that the contract offered is made available to a prospective seller for inspection prior to consummation of the sale or an offer is made to rescind the life settlement contract if the seller is not satisfied, does not remedy misleading statements. (3-29-10)

d. Advertising materials shall not use words or phrases in a manner which exaggerates any benefits beyond the terms of the life settlement contract and shall fairly and accurately describe the negative features as well as the positive features of the life settlement contract and life settlement program. An advertisement shall not represent or imply that life settlements by the provider are “liberal” or “generous,” or use words of similar import, or that benefits of a life settlement are or will be beyond the actual terms of the life settlement contract. (3-29-10)

e. Advertising materials shall not be designed to encourage or promote the purchase of life insurance for the purpose of transferring ownership to third party investors who lack an insurable interest in the life of the insured. (3-29-10)

f. An advertisement shall not create the impression directly or indirectly that a provider, a broker, its financial condition or status, a life settlement contract or program, or the payment of life settlement benefits is approved, endorsed, or accredited by any division or agency of this state or the United States Government. (3-29-10)

g. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the life settlement contract advertised and be accurately reproduced. A provider or broker 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. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the provider or broker, 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.” (3-29-10)

h. The source of any statistics used in an advertisement shall be identified in the advertisement. (3-29-10)

03. Font Size for Printed Materials. Pertinent text of all printed materials required to be filed with the director under the Life Settlement Act, including, but not limited to, notices, disclosure forms, contract forms, and advertising material, is required to be formatted using at least a twelve (12) point font. Signature blocks, footnotes or text not relevant to the understanding of the printed material may be printed in a smaller font, but in no case smaller than a ten (10) point font. (3-29-10)

04. Disapproval of Noncompliant Forms. The Director may disapprove for use in Idaho any form required to be filed pursuant to this Section if, in the opinion of the Director, the form does not comply with any part of Title 41, Idaho Code, or these rules, or the form is unreasonable in its terms, contrary to the interests of the public, misleading to the public, unfair to the owner, or is printed or provided in a manner making any part of the form substantially illegible. (3-29-10)

013. ANNUAL REPORTING REQUIREMENTS.

All persons registered with the Director as a provider shall file with the Director, on or before March 1st of each year, an annual statement. An annual report is required regardless of whether any life settlement contracts with Idaho owners were executed during the year. (3-29-10)

014. EXAMINATION AND RECORDS.

Brokers and providers are subject to examination by the Director in accordance with Chapter 2, Title 41, Idaho Code, and shall pay, at the direction of the Director, the actual travel expenses, reasonable living expense allowance, and reasonable compensation incurred on account of the examination upon presentation of a detailed account of the charges and expenses. (3-29-10)

015. REQUIRED DISCLOSURES TO OWNER.

01. Disclosure to Owner Upon Application. A broker or provider shall not provide an owner with an application for a life settlement contract unless the owner has also been provided a disclosure form containing all the information required by Idaho Code, 41-1956 and in substantially the same form as the sample form found on the Department website. The disclosures shall be provided in a separate document in at least twelve (12) point font. Each page of the disclosure document shall be initialed by the owner indicating that it has been received and read by the owner, and the final page shall be dated and signed by the owner and the broker or provider that delivered the disclosure document to the owner. (3-29-10)

02. Disclosures to Owner by Provider Upon Settlement. Prior to the time an owner signs a life settlement contract, the provider shall provide the owner a disclosure form containing all the information required by Idaho Code 41-1957 and in substantially the same form as the sample form found on the Department website. The disclosures may be made by a separate document or included as a part of the life settlement contract. If the disclosures are included in the life settlement contract, they shall be conspicuously displayed in the contract by segregating the disclosures from the rest of the contract on a separate page or as a separate section using at least twelve (12) point font and with a heading in bold font stating: "Important Disclosures Required by Law." Each disclosure page of the life settlement contract shall be initialed by the owner indicating that the owner has read the page. If the disclosures are provided in a separate document, each page of the document must be initialed by the owner and the final page shall be dated and signed by the owner and the provider. (3-29-10)

03. Disclosure to Owner by Broker Upon Settlement. Prior to the time an owner signs a life settlement contract, the broker shall provide the owner a disclosure form containing all the information required by Idaho Code 41-1958 and in substantially the same form as the sample form found on the Department website. The disclosures may be made by a separate document or included as a part of the life settlement contract. If the disclosures are included in the life settlement contract, they shall be conspicuously displayed in the contract by segregating the disclosures from the rest of the contract on a separate page or as a separate section using at least twelve (12) point font, and a heading in bold font stating: "Important Disclosures Required by Law." Each disclosure page of the life settlement contract shall be initialed by the owner indicating that the owner has read the page. If the disclosures are provided in a separate document, each page of the document must be initialed by the owner and the final page shall be dated and signed by the owner and the broker. (3-29-10)

04. Affiliations to be Disclosed. As a part of the disclosures required under this Section, a provider shall disclose in writing to the owner any affiliation between the provider and the issuer of the insurance policy to be settled, and a broker shall disclose in writing any affiliation or contractual arrangement between the broker and any person making an offer in connection with a proposed life settlement contract. (3-29-10)

016. ADDITIONAL REQUIREMENTS.

01. Owner's Statement. (3-29-10)

a. Prior to entering into a life settlement contract, the provider shall obtain from each owner a written statement in substantially the following form: "I, [owners name], have freely and voluntarily consented to the life settlement contract that accompanies this statement. I have carefully read my insurance policy that is the subject of the life settlement contract and I understand the benefits that are available under the policy. I further understand that by entering into the life settlement contract, the right to benefits under the insurance policy will be sold to another

party and I, my heirs or former beneficiaries will no longer have any right to receive those policy benefits.” (3-29-10)

b. If the owner has a terminal or chronic illness, the following wording shall also be included in the owner’s statement: “I am currently suffering from a terminal or chronic illness that was not diagnosed until after the policy that is the subject of the life settlement contract was issued.” (3-29-10)

c. The statement of the owner must also be acknowledged by a notary public. (3-29-10)

02. Owner’s Right to Rescind Life Settlement Contract. (3-29-10)

a. The life settlement contract shall conspicuously inform the owner in bold type of at least twelve (12) point font that the owner has an absolute right to rescind a life settlement contract within twenty (20) calendar days of the date the contract is executed and shall set forth the manner in which notice is to be given. (3-29-10)

b. Upon being informed of the owner’s intention or desire to rescind a life settlement contract, the provider shall immediately provide the owner with a full accounting of the amount that must be repaid by the owner in order to rescind the policy. The amount due shall include only amounts actually paid to and received by the owner pursuant to the terms of the life settlement contract along with any premiums, loans and loan interest paid by or on behalf of the provider in connection with or as a direct consequence of the life settlement contract. An owner shall not be required to pay any financial penalties, liquidated damages or other punitive fees or charges in connection with rescission of a life settlement contract. (3-29-10)

c. Until the owner receives from the provider an accounting of the full and correct repayment amount needed to rescind the life settlement contract, a tender of payment by the owner of amounts actually received and reasonably believed to be due upon rescission shall be deemed substantial compliance with the requirement of notice and repayment of proceeds within the twenty (20) day rescission period. (3-29-10)

03. Life Settlements Occurring Within Two Years of Policy Origination. (3-29-10)

a. No broker or provider shall solicit, arrange for or enter into a life settlement contract within two (2) years of the date of issuance of the life insurance policy or certificate being settled unless one (1) or more of the conditions identified in Section 41-1961, Idaho Code, applies. If one (1) or more of the conditions is present, the provider shall obtain from the owner a written statement sworn before a notary public setting forth in detail the circumstances permitting the early settlement of the contract. The sworn statement shall also include the following or substantially similar wording: “I hereby affirm that there was no plan or arrangement in place or under discussion, or any promises made, regarding the settlement of this life insurance policy at the time the policy was purchased.” (3-29-10)

b. In addition to the sworn statement, the provider shall obtain and retain as a part of its records independent documentation of the circumstances permitting early settlement of the life insurance policy along with all documentation relating to any premium financing arrangements made in connection with the policy being settled. (3-29-10)

c. The sworn statement and copies of all supporting documentation shall be provided to the insurer at the time a request for verification of coverage is submitted to the insurer. A request for verification of coverage relating to a policy or certificate that has been in effect for two (2) years or less will be considered incomplete if it is not accompanied by the owner’s sworn statement and supporting documentation. An insurer that determines a request for verification of coverage is incomplete shall, without undue delay, inform the broker or provider in writing that the verification is incomplete and identify all items needed to complete the request. (3-29-10)

017. -- 999. (RESERVED)

**IDAPA 18
TITLE 03
CHAPTER 03**

18.03.03 – VARIABLE CONTRACTS

000. LEGAL AUTHORITY.

Title 41, Chapter 19, Idaho Code.

(7-1-93)

001. PURPOSE.

The purpose of these rules is to provide a comprehensive plan: for the qualification and licensing of insurers to write policies or contracts on a variable basis; for establishment of separate accounts and the investment of assets contained therein; for the filing and approval of policy and contract forms; for reports to contract holders; for the qualification, examination and licensing of agents and other persons; providing for the establishment and preservation of certain records and the establishment of other standards pertaining to the offering and sale of such contracts.

(7-1-93)

002. -- 003. (RESERVED).

004. DEFINITIONS.

01. Variable Contracts. The term "Variable Contract" means any policy or contract, whether on an individual or group basis, which provides for insurance or annuity benefits which vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract.

(7-1-93)

02. Agent. "Agent" when used in this rule, means any person, corporation, partnership, or other legal entity which under the laws of this state is licensed as a life insurance agent.

(7-1-93)

03. Variable Contract Agent. "Variable Contract Agent," when used in this rule, means an agent who sells or offers to sell any contract on a variable basis.

(7-1-93)

04. Satisfactory Alternative Examination. A "Satisfactory Alternative Examination" to Part I of the written examination includes any securities examination which is declared by the Director to be an equivalent examination on the basis of content and administration. The following examinations are deemed to be a satisfactory alternative examination:

(7-1-93)

a. The National Association of Securities Dealers, Inc., Examination for Principals, or Examination for Qualification as a Registered Representative;

(7-1-93)

b. The various securities examinations required by the New York Stock Exchange, the American Stock Exchange, or the Pacific Coast Stock Exchange;

(7-1-93)

c. The Securities and Exchange Commission test given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934, as amended;

(7-1-93)

d. The examination recommended for the testing of variable contract agents by the National Association of Insurance Commissioners, when adopted by the Insurance Department of any State or Territory of the United States and approved for use by such Department by the Securities and Exchange Commission; and

(7-1-93)

e. Any State Securities Sales Examination accepted by the Securities and Exchange Commission.

(7-1-93)

005. -- 010. (RESERVED).

011. QUALIFICATIONS OF INSURANCE COMPANIES TO ISSUE VARIABLE CONTRACTS.

01. Insurer Requirements. No insurer shall deliver or issue for delivery in this state contracts authorized under Section 41-1936, Idaho Code, unless it is authorized or organized to do a life insurance or annuity business in this state, and the Director is satisfied that its condition or method of operation in connection with the

issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Director shall consider among other things: (7-1-93)

- a. The history and financial condition of the insurer; (7-1-93)
- b. The character, responsibility and fitness of the officers and directors of the insurer; and (7-1-93)
- c. The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts. (7-1-93)

02. Parent or Affiliated Insurer. An insurer which issues variable contracts and which is a subsidiary of, or affiliated through common management or ownership with, another life insurer authorized to transact such insurance in this state shall be deemed to have met the provisions of this section if either it or the parent or affiliated insurer meets the requirements hereof. (7-1-93)

03. Title 41, Chapter 3, Idaho Code, Requirements. No insurer which does not satisfy the requirements of Title 41, Chapter 3 of the Idaho Insurance Code, nor which is not then possessed of such capital and surplus as is then required for a new life insurer under the Idaho Insurance Code or under the statutes of its state or place of incorporation, whichever is greater, shall be qualified to issue variable contracts. (7-1-93)

04. Delivery. Before any insurer shall deliver or issue for delivery variable contracts within this state, it shall submit to the Director a general description of the kinds of variable contracts it intends to issue; (6-30-19)T

012. SEPARATE ACCOUNTS.

01. Domestic Life Insurer. A domestic life insurer issuing variable contracts shall establish one or more separate accounts pursuant to Sections 41-1936 and 41-734 of the Idaho Insurance Code subject to the following provisions of this Rule: (7-1-93)

a. Except as hereinafter provided, amounts allocated to any separate account and accumulation thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; provided, that to the extent that the company's reserve liability with regard to: (a) benefits guaranteed as to dollar amount and duration, and (b) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be, except as the Director may otherwise approve, invested in accordance with the laws of this state governing the investments of life insurance companies. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the insurer. (7-1-93)

b. With respect to seventy-five percent (75%) of the market value of the total assets in a separate account no insurer shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market value, would exceed ten percent (10%) of the market value of the assets of said separate account; provided, however, that the Director may waive such limitation if, in his opinion, such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this state. (7-1-93)

c. Unless otherwise permitted by law or approved by the Director, no insurer shall purchase or otherwise acquire for its separate accounts the voting securities of any issuer if as a result of such acquisition the insurance company and its separate accounts, in the aggregate, will own more than ten percent (10%) of the total issued and outstanding voting securities of such issuer; provided, that the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interests in such accounts. (7-1-93)

d. The limitations provided in Subsections 012.01.b. and 012.01.c. above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, provided that the investments of such investment company comply in substance

with Subsections 012.01.b. and 012.01.c. hereof.

(7-1-93)

02. Valuation of Assets. Unless otherwise approved by the Director, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; except, that unless otherwise approved by the Director, a portion of the assets of such separate account equal to the company's reserve liability with regard to the benefits and funds referred to in Subsections 012.01.a. and 012.01.b. of this Section, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

(7-1-93)

03. Chargeability of Assets with Liabilities. That portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct. Notwithstanding any other provisions of law an insurer may:

(7-1-93)

a. With respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust, exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the insurer, or

(7-1-93)

b. With respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the insurer. Such committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets. An insurer, committee, board or other body, may make such other provisions in respect to any such separate account as may be deemed appropriate to facilitate compliance with requirements of any Federal or State law now or hereafter in effect; provided that the Director approves such provisions as not hazardous to the public or the company's policyholders in this state.

(7-1-93)

04. Sale, Exchange, Transfer. No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (a) by a transfer of cash, or (b) by a transfer of securities having a valuation which could be readily determined in the marketplace, provided that such transfer of securities is approved by the Director. The Director may authorize other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

(7-1-93)

05. Assets Equal to Reserves and Liabilities. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account.

(7-1-93)

06. Officers and Directors. Rules under any provision of the Insurance Law of this state of any rule applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee, board or other similar body. No officer or director of such company nor any member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

(7-1-93)

013. FILING OF CONTRACTS.

The filing requirements applicable to variable contracts shall be those filing requirements otherwise applicable under existing statutes and rules of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate. In addition, each insurer shall file with the Director a copy of each prospectus adopted by it for use in conjunction with the sale of any contract offered for sale in this state.

(7-1-93)

014. CONTRACTS PROVIDING FOR VARIABLE BENEFITS.

01. Benefits Payable in Variable Amounts. Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis. (7-1-93)

02. Illustrations. Illustrations of benefits payable under any variable contract providing benefits payable in variable amounts shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of annuity payments. (7-1-93)

03. Payment of Periodic Stipulated Payments. No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or provisions which in the opinion of the Director are more favorable to the holders of such contracts: (7-1-93)

a. A provision that there shall be a period of grace of one month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom; (7-1-93)

b. A provision that, at any time within one (1) year from the date of default in making periodic stipulated payments to the insurer during the life of the annuitant, unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and payment or reinstatement of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom; (7-1-93)

c. A provision specifying the options available in the event of default in a periodic stipulated payment. Such options may include an option to surrender the contract for a cash value as determined by the contract, and shall include an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of such paid-up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract. (7-1-93)

04. Investment Increment Factor. Any individual variable annuity contract delivered or issued for delivery in this state shall stipulate the investment increment factor to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and may guarantee that expense and/or mortality results shall not adversely affect such dollar amounts. If not guaranteed, the expense and mortality factors shall also be stipulated in the contract. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable contract: (7-1-93)

a. The annual net investment increment assumption shall not exceed five percent (5%), except with the approval of the Director. (7-1-93)

b. To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the Director, from another table. (7-1-93)

c. "Expense," as used in this subsection, may exclude some or all taxes, as stipulated in the contract. (7-1-93)

05. Payment on Death. Variable annuity contracts may include as an incidental benefit provision for payment on death during the deferred period of an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at time of death. Any such provision shall not

be subject to the provisions of the insurance law governing life insurance contracts. A provision for any other benefit on death during the deferred period shall be subject to such insurance law provisions. (7-1-93)

06. Reserve Liability. The reserve liability for variable contracts shall be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided, and any mortality guarantees. (7-1-93)

015. REQUIRED REPORTS.

01. Statement Reporting the Investments. Any insurer issuing individual variable contracts providing benefits in variable amounts shall mail to the contract holder at least once in each contract year after the first at his last address known to the company, a statement or statements reporting the investments held in the separate account and, in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four (4) months previous to the date of mailing, (a) the number of accumulation units credited to such contracts and the dollar value of a unit, or (b) the value of the contract holder's account. (7-1-93)

02. Statement of Business to Director. The insurer shall submit annually to the Insurance Director a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners. (7-1-93)

016. FOREIGN INSURERS.

If the law or rule in the place of domicile of a foreign insurer provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these rules, the Director, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or rule as compliance with these rules. (7-1-93)

017. -- 018. (RESERVED).

019. SEVERABILITY.

If any provision of this Rule shall be held invalid, the remainder of the Rule shall not be affected thereby. (7-1-93)

020. -- 999. (RESERVED).

**IDAPA 18
TITLE 03
CHAPTER 04**

18.03.04 – REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

000. LEGAL AUTHORITY.

Title 41, Sections 1305 and 1327, Idaho Code, and Title 67, Chapter 52, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

The purpose of this rule is: (7-1-93)

01. Insurers, Agents and Brokers. To regulate the activities of insurers, agents and brokers with respect to the replacement of existing life insurance and annuities. (7-1-93)

02. Minimum Standards. To protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement transactions by: (7-1-93)

a. Assuring that purchasers receive adequate information upon which to base a decision that will be in their best interest; (7-1-93)

b. Reducing the opportunity for misrepresentations and incomplete disclosures; and (7-1-93)

c. Establishing penalties for failure to comply with requirements of this rule. (7-1-93)

002. -- 003. (RESERVED)

004. DEFINITION OF REPLACEMENT.

“Replacement” means any transaction by 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 existing life insurance or an annuity has been or is to be: (7-1-93)

01. Termination. Lapsed, forfeited, surrendered, or otherwise terminated. (7-1-93)

02. Conversion or Continuance. 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. (7-1-93)

03. Amendment. 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. (7-1-93)

04. Reissuance. Reissued with any reduction in cash value. (7-1-93)

05. Loans. 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 (25%) of the loan value set forth in the policy. (7-1-93)

005. OTHER DEFINITIONS.

01. Conservation. “Conservation” means any attempt by the existing insurer or its agent or broker to dissuade a policy owner from the replacement of existing life insurance or annuity. Conservation does not include such routine administrative procedures such as late payment reminders, late payment offers or reinstatement offers. (7-1-93)

02. Direct-Response Sales. “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. (7-1-93)

03. Existing Insurer. “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.” (7-1-93)

04. Existing Life Insurance or Annuity. “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. (7-1-93)

05. Replacing Insurer. “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. (7-1-93)

006. -- 010. (RESERVED)

011. EXEMPTIONS.

Unless otherwise specifically included, this rule shall not apply to transactions involving: (7-1-93)

01. Credit Life Insurance. (7-1-93)

02. Group Life Insurance or Group Annuities. (7-1-93)

03. Existing Insurer. An application to the insurer that issued the existing life insurance and a contractual change or conversion privilege being exercised; (7-1-93)

04. Binding or Conditional Receipt Issued by Same Company. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company. (7-1-93)

05. Common Ownership or Control. 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 Subsection 012.01. (7-1-93)

012. DUTIES OF AGENTS AND BROKERS.

01. Statement Submitted to Insurer. 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: (7-1-93)

a. A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction; and (7-1-93)

b. A signed statement as to whether the agent or broker knows replacement is or may be involved in the transaction. (7-1-93)

02. Notice to Applicant. Where a replacement is involved, the agent or broker shall: (7-1-93)

a. Present to the applicant, not later than at the time of taking the application, a “Notice Regarding Replacement” in the form as described in Exhibit A, or other substantially similar form approved by the Director. The notice shall be signed by both the applicant and the agent or broker and left with the applicant. (7-1-93)

b. Obtain with or as part of each application a list of all existing life insurance and/or annuities to be replaced and properly identified by name of insurer, the insured and contract number. If a contract number has not been assigned by the existing insurer, alternative identification, such as an application or receipt number, shall be listed. (7-1-93)

c. Leave with the applicant the original or a copy of written or printed communications used for presentation to the applicant. (7-1-93)

d. Submit to the replacing insurer with the application a copy of the replacement notice provided pursuant to Subsection 012.02.a. (7-1-93)

03. Conservation. 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. (7-1-93)

013. DUTIES OF ALL INSURERS.

Each insurer shall: (7-1-93)

01. Notice to Representatives of Rule. Inform its field representatives or other personnel responsible for compliance with this rule of the requirements of this rule. (7-1-93)

02. Application. Require with or as a 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. (7-1-93)

014. DUTIES OF INSURERS THAT USE AGENTS OR BROKERS.

Each insurer that uses an agent or broker in a life insurance or annuity sale shall: (7-1-93)

01. Statement by Agent or Broker. 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 if replacement is involved in the transaction. (7-1-93)

02. Replacement Notice and List of Existing Insurance. Where a replacement is involved: (7-1-93)

a. Require from the agent or broker with the application for life insurance or annuity a list of all of the applicant's existing life insurance or annuities to be replaced and a copy of the replacement notice provided the applicant pursuant to Section 012. 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. (7-1-93)

b. Send to each existing insurer a written communication advising of the replacement or proposed replacement and the identification information obtained pursuant to Subsection 014.02.a. and a policy summary or ledger statement containing policy data on the proposed life insurance or annuity as required by the model life insurance solicitation rule and/or the model annuity and deposit fund disclosure rule. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary or ledger statement. This written communication shall be made within five (5) 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. (7-1-93)

c. Each existing insurer, or such insurer's agent or broker that undertakes a conservation shall within twenty (20) days from the date the written communication plus the materials required in Subsections 014.02.a. and 014.02.b. is received, furnish the policy owner 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 information relating to premiums, cash values, death benefits and dividends, if any, and shall be computed from the current policy year of the existing life insurance. The policy summary 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 rule or statute. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary. When annuities are involved, the disclosure information shall be that required in a contract summary under the annuity and deposit fund disclosure rule. The replacing insurer may request the existing insurer to furnish it with a copy of the summaries. (7-1-93)

03. Maintenance of Records. 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 (3) years or until the conclusion of the next succeeding regular examination by the insurance department of its state of domicile, whichever is later. (7-1-93)

04. Refund. 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 a period of twenty (20) days commencing from the date of delivery of the policy. (7-1-93)

**IDAPA 18
TITLE 03
CHAPTER 05**

18.03.05 – CREDIT LIFE AND CREDIT DISABILITY INSURANCE

000. LEGAL AUTHORITY.

This rule chapter is promulgated pursuant to the rule making authority in Sections 41-211 and 41-2314, Idaho Code, to aid in the interpretation and implementation of Chapter 23, Title 41, Idaho Code, concerning credit life and credit disability insurance. Nothing in this rule chapter applies to insurance for which no identifiable charge is made to the debtor. (7-1-93)

001. TITLE AND SCOPE.

The purpose of this rule chapter is to protect the interests of debtors and the public in this state by providing a system of rate, policy form, and operating standards for the transaction of credit life and credit disability insurance. (7-1-93)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (5-8-09)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, the Idaho Administrative Procedure Act, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," Subchapter A - General Provisions, Sections 000 through 099., (5-8-09)

004. INCORPORATION BY REFERENCE.

No documents are incorporated by reference. (5-8-09)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (5-8-09)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (5-8-09)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (5-8-09)

04. Web Site Address. The department's website is <http://www.doi.idaho.gov>. (5-8-09)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (5-8-09)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Closed-End Credit. Means a credit transaction that is not open-end credit. (7-1-93)

02. Compensation. Means money or anything else of value. (7-1-93)

03. Credit Disability Insurance. Means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy. (7-1-93)

04. Credit Insurance. Means both credit life insurance and credit disability insurance. (7-1-93)

05. Credit Life Insurance. Means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction. (7-1-93)

06. Credit Transaction. Means any transaction by the terms of which the repayment of money loaned or loan commitment made, or payment for goods, services or properties sold or leased, is to be made at a future date or dates. (7-1-93)

07. Creditor. Means the lender of money or vendor of goods, services or property, rights or privileges, including a lessor under a lease intended as security for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender or vendor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them. (7-1-93)

08. Debtor. Means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction. (7-1-93)

09. Identifiable Charge. The amount the debtor is charged for insurance which is disclosed in the credit or other instrument furnished the debtor which sets out the financial elements of the credit transactions, and including any differential in finance, interest, service or other similar charge made to debtors who are in like circumstances, except for their insured or noninsured status. (7-1-93)

10. Indebtedness. Means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction. (7-1-93)

11. Net Written Premium. Means gross written premium minus refunds on terminations. (7-1-93)

12. Open-End Credit. Means an arrangement as defined in Section 28-41-301(25), Idaho Code, including revolving charge accounts, pursuant to which: (7-1-93)

a. A creditor may permit a debtor, from time to time, to purchase on credit from the creditor or pursuant to a credit card, or to obtain loans from the creditor or pursuant to a credit card; (7-1-93)

b. The amounts financed and the finance and other appropriate charges are debited to an account; (7-1-93)

c. The finance charge, if made, is computed on the account periodically; and (7-1-93)

d. Either the debtor has the privilege of paying in full or in installments or the creditor periodically imposes charges computed on the account for delaying payment and permits the debtor to continue to purchase on credit. (7-1-93)

13. Preexisting Condition. Means a health condition, including sickness or injury, for which there has been medical advice, diagnosis or treatment within six (6) months preceding the effective date of the debtor's coverage and which exists prior to the effective date of the coverage. (7-1-93)

011. RIGHTS AND TREATMENT OF DEBTORS.

01. Multiple Plans of Insurance. If a creditor makes available to the debtors more than one plan of credit life insurance or more than one plan of credit disability insurance, all debtors must be informed of all such plans for which they are eligible. (7-1-93)

02. Substitution. When a creditor requires credit life insurance, credit disability insurance, or both, as additional security for an indebtedness, the debtor shall be given the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or by procuring and furnishing the required coverage through any insurer authorized to transact insurance business in this state. If this subsection is applicable, the debtor shall be informed by the creditor of the right to provide alternative coverage before the

transaction is completed. (7-1-93)

03. Evidence of Coverage. (7-1-93)

a. All credit insurance shall be evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance. The individual policy or certificate of insurance shall be delivered to the debtor in accordance with Section 41-2311, Idaho Code. (7-1-93)

b. Each individual policy or certificate of insurance shall set forth such information as required by Section 41-2308, Idaho Code, and any other appropriate sections of the Idaho Insurance Code. (7-1-93)

04. Claims Processing. All credit insurance claims shall be processed in accordance with Sections 41-1329 and 41-2312, Idaho Code. (7-1-93)

05. Termination of Group Credit Insurance Policy. (7-1-93)

a. If a debtor is covered by a group credit insurance policy providing for the payment of single premiums to the insurer, then provision shall be made by the insurer that in the event of termination of the policy for any reason, insurance coverage with respect to any debtor insured under such policy shall be continued for the entire period for which the single premium has been paid. (7-1-93)

b. If a debtor is covered by a group credit insurance policy providing for the payment of premiums to the insurer on a monthly outstanding balance basis, then the policy shall provide that, in the event of termination of such policy for whatever reason, termination notice thereof shall be given to the insured debtor at least thirty (30) days prior to the effective date of termination except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The notice required in this paragraph shall be given by the insurer or, at the option of the insurer, by the creditor. (7-1-93)

06. Interest on Premiums. If any direct or indirect finance, carrying, credit or service charge is made to the debtor on such insurance charges or premiums, the creditor must remit and the insurer shall collect such premium within sixty (60) days after it is added to the indebtedness. (7-1-93)

07. Renewal or Refinancing of the Indebtedness. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of such termination prior to scheduled maturity, a refund shall be paid or credited to the debtor as provided in Section 017. In any renewal or refinancing of the indebtedness, the effective date of the coverage as respects any policy provision shall be deemed to be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least to the extent of the amount and term of the indebtedness outstanding at the time of renewal and refinancing of the debt. In addition, the policy shall provide that, in the event the debtor becomes disabled while insured, credit disability insurance benefits will be payable during continued disability regardless of any termination of the insurance by renewal or refinancing, unless a different provision not less favorable to the debtor is approved by the director. (7-1-93)

08. Maximum Aggregate Provisions. A provision in a policy or certificate that sets a maximum limit on total payments must apply only to that policy or certificate except as may be provided for in Section 41-2005(4), Idaho Code. (7-1-93)

09. Voluntary Prepayment of Indebtedness. If a debtor prepays the indebtedness other than as a result of death or through a lump sum disability payment: (7-1-93)

a. Any credit life insurance covering such indebtedness shall be terminated and an appropriate refund of the credit life insurance premium shall be paid to the debtor in accordance with Section 017; and (7-1-93)

b. Any credit disability insurance covering such indebtedness shall be terminated and an appropriate refund of the credit disability insurance premium shall be paid to the debtor in accordance with Section 017. If a claim under such coverage is in progress at the time of prepayment, the amount of refund may be determined as if the

prepayment did not occur until the payment of benefits terminates. No refund need be paid during any period of disability for which credit disability benefits are payable. A refund shall be computed as if prepayment occurred at the end of the disability period. (7-1-93)

10. Involuntary Prepayment of Indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit insurance policy covering the debtor, then it shall be the responsibility of the insurer to see that the following are paid to the insured debtor, if living, or the beneficiary, other than the creditor, named by the debtor or to the debtor's estate: (7-1-93)

a. In the case of prepayment by the proceeds of a credit life insurance policy, or by the proceeds of a lump sum total and permanent disability benefit under credit life coverage, an appropriate refund of the credit disability insurance premium in accordance with Section 017; (7-1-93)

b. In the case of prepayment by a lump sum disability claim, an appropriate refund of the credit life insurance premium in accordance with Section 017; (7-1-93)

c. In either case, the amount of the benefits in excess of the amount required to repay the indebtedness after crediting any unearned interest or finance charges. (7-1-93)

11. Amounts to be Insured: (7-1-93)

a. Credit life insurance benefits shall be consistent with the premium charge. Credit life insurance may provide benefits in amounts which do not exceed, but may be less than, the initial amount of indebtedness, including unearned interest or finance charges, or the actual amount of unpaid indebtedness, whichever is greater. (7-1-93)

b. Credit disability insurance may provide benefits not exceeding an amount according to Section 41-2306(2), Idaho Code. (7-1-93)

c. If benefits to be provided are less than the scheduled amount of indebtedness, the insurer shall notify the insured of such benefit in the policy or certificate. (7-1-93)

12. Total Disability. The policy shall not restrict coverage to those periods of total disability when the debtor is under the regular and continuing care of a physician, osteopath or chiropractor; provided, the insurer may retain the right to require medical evidence of actual total disability at reasonable intervals to justify the commencement and continued payment of benefits. (7-1-93)

13. Permanent Disabilities. Credit disability insurance shall not restrict coverage to permanent disabilities, where the debtor is in fact totally disabled for the period required by the policy, although such disability may be of a temporary nature. (7-1-93)

14. Statement by Debtor. No statement made by a debtor shall be used by the insurer as a basis for denying eligibility for coverage unless such statement is contained in a written application for insurance signed by the debtor. (7-1-93)

15. Acceptable Insurance Constituting Waiver. Acceptance of insurance by the insurer shall constitute a waiver of any conditions for issuance of insurance that the debtor's application revealed as breached on the date the application was made, unless a refund of all insurance charges to the debtor is actually made within thirty (30) days of the date the coverage became effective. (7-1-93)

012. POLICY FORMS AND RELATED MATERIAL.

01. Permissible Forms. Credit life and credit disability insurance shall be issued only in the forms described in Section 41-2305, Idaho Code. (7-1-93)

02. Filing Requirements. All policy forms, certificates of insurance, notices of proposed insurance,

applications for insurance, endorsements and riders to be delivered or issued for delivery in this state and the schedules of maximum premium rates pertaining thereto shall be filed with the director as required by Section 41-2309, Idaho Code, and other applicable Department of Insurance Bulletins and Rules. (7-1-93)

013. DETERMINATION OF REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGE.

01. General Standard. Benefits provided by credit insurance policies must be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or is expected to develop a loss ratio of not less than fifty percent (50%). The Department of Insurance has established prima facie rates as a means to achieve the loss ratio benchmark. With the exception of deviations approved under Section 019, prima facie rates filed in accordance with Section 014 as adjusted pursuant to Section 018, shall be conclusively presumed to satisfy this general standard. Reporting forms throughout the period of coverage. (7-1-93)

02. Nonstandard Coverage. If any insurer files for approval of any form, providing coverage more restrictive than that described in Section 014, the insurer shall demonstrate to the satisfaction of the director that the premium rates to be charged for such restricted coverage will develop or may reasonably be expected to develop a loss ratio not less than that contemplated for standard coverage at the premium rates described in these sections. (7-1-93)

014. PRIMA FACIE RATES.

01. Credit Life Insurance Prima Facie Rates. (7-1-93)

a. Premium Rate. Premium rates for credit life insurance on a single life for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment paid, shall be as set forth in Subsections 014.01.a.i. and 014.01.a.ii. Subsection 014.01.a.iii. refers to single life premium rates for other types of benefits either alone or in combination with the type of benefits applicable to Subsections 014.01.a.i. and 014.01.a.ii. (7-1-93)

i. Eighty-six cents (\$0.86) per month per one thousand dollars (\$1,000) of outstanding insured indebtedness if premiums are payable on a monthly outstanding balance basis. (7-1-93)

ii. Gross coverage - Decreasing term: fifty-four cents per one hundred dollars of initial insured indebtedness per year (\$0.54/\$100/year) if premiums are payable on a single premium basis and the amount of the insurance decreases in equal monthly amounts. (7-1-93)

iii. Level term: One Dollar per one hundred dollars of initial insured indebtedness per year (\$1/\$100/year) if premiums are payable on a single premium basis for an amount of insurance that remains constant throughout the period of coverage. (7-1-93)

iv. Joint coverage on either of the basis in Subsection 014.01.a.i., 014.01.a.ii., or 014.01.a.iii. shall be one hundred sixty five percent (165%) of the specified rate for that type of coverage. (7-1-93)

v. A combination of the appropriate rate for level term and the appropriate rate for decreasing term (with equal decrements), if coverage provided is a combination of level term and decreasing term (with equal decrements). (7-1-93)

vi. If the benefits provided are other than those described in the introduction to this subsection, premium rates for such benefits shall be actuarially consistent with the rates provided in Subsections 014.01.a.i., 014.01.a.ii., 014.01.a.iii., and 014.01.a.iv. (7-1-93)

vii. If the policy provisions are other than those that correspond to the use of rates provided for in this Rule chapter, those other provisions shall not be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. (7-1-93)

02. Credit Disability Insurance Prima Facie Rates. (7-1-93)

a. Premium Rate. Credit disability insurance premium rates for the insured portion of an indebtedness repayable in equal monthly installments, where the insured portion of the indebtedness decreases uniformly by the amount of the monthly installment payable, shall be as set forth in Subsection 014.02.a.ii and iii. Subsection 014.02.a.014.02.iii., 014.02.iv., and 014.02.v. refer to premium rates for other types of benefits either alone or in combination with the type of benefits applicable to Subsection 014.02.a.i. and 014.02.a.ii. (7-1-93)

i. If premiums are payable on a single-premium basis for the duration of the coverage, the premium rates for one hundred dollars (\$100) of initial indebtedness repayable shall be as set forth in the following table utilizing straight line interpolation for the intervening months; or

No. Months Indebtedness Is Repayable	Non-Retroactive Benefits		Retroactive Benefits		
	14 Day - 30 Day		7 Day	14 Day	30 Day
6	\$1.00	\$.40	\$2.60	\$1.80	\$1.30
2	1.40	.80	3.00	2.20	1.70
24	2.20	1.60	4.00	3.00	2.50
36	3.00	2.40	5.00	3.80	3.30
48	3.50	2.90	5.70	4.30	3.80
60	3.90	3.30	6.30	4.70	4.20
72	4.30	3.70	NA	5.10	4.60
84	4.70	4.10	NA	5.50	5.00
96	5.10	4.50	NA	5.90	5.40
108	5.50	4.90	NA	6.30	5.80
120	5.90	5.30	NA	6.70	6.20

NA - Not Available

(7-1-93)

ii. If premiums are paid on the basis of a premium rate per month per thousand of outstanding insured indebtedness, these premiums shall be computed according to the following formula or according to a formula approved by the director which produces rates actuarially consistent to the single premium rates:

$$Op(n) = \frac{20Sp(n)}{n+1}$$

Where Sp = Single Premium Rate per one hundred dollars (\$100) of initial insured indebtedness repayable in n equal monthly installments.

Op - Monthly Outstanding Balance Premium Rate per one thousand dollars (\$1,000).

n - Original repayment period, in months.

(7-1-93)

iii. The actuarial equivalent of Subsections 014.02.a.i. and 014.02.a.ii. shall be used if the coverage provided is a constant maximum indemnity for a given period of time. (7-1-93)

iv. An appropriate combination of the premium rate for a constant maximum indemnity for a given period of time and the premium rate for a maximum indemnity which decreases in even amounts per month, if the

coverage provided is a combination of a constant maximum indemnity for a given period of time after which the maximum indemnity begins to decrease in even amounts per month. (7-1-93)

v. If the benefits provided are other than those described in Subsection 014.02.a.i. above, rates for such benefits shall be actuarially consistent with rates provided in Subsections 014.02.a.i., 014.02.a.ii., 014.02.a.iii., and 014.02.a.iv. (7-1-93)

vi. The outstanding balance rate for credit disability insurance may be either a term-specified rate or may be a single composite term outstanding balance rate applicable to all loans. (7-1-93)

vii. If the policy provisions are other than those that correspond to the use of rate provided for in this Rule chapter, those other provisions shall not be unfair, just, inequitable, misleading, or deceptive; encourage misrepresentations of the coverage; or be contrary to statute or administrative rule. (7-1-93)

015. CREDIT LIFE INSURANCE.

Premium rates in conformance with Section 014 shall apply to policies providing credit life insurance to be issued with or without evidence of insurability, to be offered to all debtors, and containing: (7-1-93)

01. Exclusions. No exclusions other than suicide within six (6) months of the incurred indebtedness; and (7-1-93)

02. Age Restrictions. Either no age restrictions or age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors having attained age seventy (70) or over on the maturity date of the indebtedness. (7-1-93)

03. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance, classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65). (7-1-93)

04. Closed-End Credit Plans. On insurance written in connection with closed-end credit plans and open-end credit plans where the amount of insurance is based on or limited to the outstanding unpaid balance, no provision excluding or denying a claim for death resulting from a preexisting condition except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6) months preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within six (6) months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the plan account is the date on which the advance or charge is posted to the plan account. Other more restrictive provisions may be used subject to appropriate rate adjustment approved by the director. (7-1-93)

05. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions shall not be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. (7-1-93)

016. CREDIT DISABILITY INSURANCE.

Premium rates in conformance with Section 014 shall apply to policies providing credit disability insurance to be issued with or without evidence of insurability, to be offered to all eligible debtors, and containing: (7-1-93)

01. Preexisting Conditions. No provision excluding or denying a claim for disability resulting from preexisting conditions except for those conditions for which the insured debtor received medical advice, diagnosis or treatment within six (6) months preceding the effective date of the debtor's coverage and which caused loss within the six (6) months following the effective date of coverage. (7-1-93)

02. Other Exclusions or Restrictions. No other provision which excludes or restricts liability in the event of disability caused in a specific manner except that it may contain provisions excluding or restricting coverage in the event of normal pregnancy and intentionally self-inflicted injuries or disability arising out of the commission of felony acts. (7-1-93)

03. Actively-at-Work Requirement. No actively-at-work requirement more restrictive than one (1) requiring that the debtor be actively at work at a full-time gainful occupation on the effective date of coverage. "Full time" means a regular work week of not less than thirty (30) hours. A debtor shall be deemed to be actively at work if absent from work due solely to regular day off, holiday or paid vacation. (7-1-93)

04. Age Restrictions. No age restrictions, or only age restrictions making ineligible for coverage debtors sixty-five (65) or over at the time the indebtedness is incurred or debtors who will have attained age sixty-six (66) or over on the maturity date of the indebtedness. (7-1-93)

05. Daily Benefit. A daily benefit equal in amount to one thirtieth (1/30) of the monthly benefit payable under the policy for the indebtedness. (7-1-93)

06. Definition of Disability. A definition of "disability" which provides that during the first twelve (12) months of disability the insured shall be unable to perform the substantial and material duties of his occupation at the time the disability occurred, and thereafter the duties of any occupation for which the insured is reasonably fitted by education, training or experience. This Subsection 016.06 shall not apply to lump sum disability coverage. (7-1-93)

07. Open-End Credit Plan. Insurance written in connection with an open-end credit plan may exclude from the classes eligible for insurance classes of debtors determined by age, and provide for the cessation of insurance or reduction in the amount of insurance upon attainment of not less than age sixty-five (65). (7-1-93)

08. Other Provisions. If the policy provisions are other than those that correspond to the use of rates provided for in Section 014, those other provisions shall not be unfair, unjust, inequitable, misleading, or deceptive; encourage misrepresentation of the coverage; or be contrary to statute or administrative rule. (7-1-93)

09. Effective Date of Coverage. For the purposes of Subsections 016.01 and 016.03, the effective date of coverage for each part of the insurance attributable to a different advance or charge to an open-end credit plan account is the date on which the advance or charge is posted to the plan account. (7-1-93)

017. REFUND FORMULAS.

01. Filing and Approval by the Director. Any refund formula which is at least as favorable to the insured debtor as the "sum of the digits" formula, or the "Rule of 78," for single premium decreasing or disability plans or pro-rata for other plans, shall be deemed acceptable. Refund formulas must be filed with and approved by the director prior to use in accordance with Section 41-2310 (2), Idaho Code. (7-1-93)

02. Termination. In the event of termination, no charge for credit insurance may be made for the first fifteen (15) days of a loan month and a full month may be charged for sixteen (16) days or more of a loan month. (7-1-93)

03. Minimum Refund. No refund of five dollar (\$5) or less need be made. (7-1-93)

018. EXPERIENCE REPORTS AND ADJUSTMENT OF PRIMA FACIE RATES.

01. Report of Credit Life and Credit Disability Business Written. Each insurer doing credit insurance business in this state shall annually file with the director and the NAIC Support and Services Office a report of credit life and credit disability business written on a calendar year basis. Such report shall utilize the Credit Insurance Supplement-Annual Statement Blank as approved by the National Association of Insurance Commissioners. Such filing shall be made in accordance with and no later than the due date in the Instructions to the Annual Statement. (7-1-93)

02. Review of Loss Ratio Standards. Set Forth in Section 014. In 1995, and on a triennial basis thereafter, the director will review the loss ratio standards set forth in Section 013 and the prima facie rates set forth in Section 014 and determine therefrom the rate of expected claims on a statewide basis, compare such rate of expected claims with the rate of actual claims for the preceding three years determined from the incurred claims and earned premiums at prima facie rates reported in the Annual Statement Supplement, and may, if deemed necessary, revise the

actual statewide prima facie rates by amendment of this Rule chapter to be used by insurers during the next three years. Such rates will reflect the difference between (a) actual claims based on experience; and (b) expected claims based on the loss ratio standards set forth in Section 013 applied to the prima facie rates set forth in Section 014.

(7-1-93)

019. USE OF RATES - DIRECT BUSINESS ONLY.

01. Use of Prima Facie Rates. An insurer that files rates or has rates on file that are not in excess of the prima facie rates shown in Section 014, to the extent adjusted pursuant to Section 018, may use those rates without further proof of their reasonableness.

(7-1-93)

02. Use of Rates Higher Than Prima Facie Rates. An insurer may file for approval of and use rates that are higher than the prima facie rates established pursuant to Section 018, to the extent adjusted, if it can be expected that the use of such higher rates will result in a ratio of claims incurred to premiums earned (assuming the use of such higher rates) that is not less than fifty percent (50%) for those accounts to which such higher rates apply and that such upward deviations will not result on a statewide basis for that insurer of a ratio of claims incurred to premiums earned of less than the expected loss ratio underlying the current prima facie rate developed or adjusted pursuant to Section 018. If rates higher than the prima facie rates shown in Section 014, to the extent adjusted pursuant to Section 018, are filed for approval, the filing shall specify the accounts to which such rates apply. Such rates may be:

(7-1-93)

a. Applied uniformly to all accounts of the insurer; or

(7-1-93)

b. Applied on an equitable basis approved by the director to only one (1) or more accounts of the insurer for which the experience has been less favorable than expected; or

(7-1-93)

c. Applied according to a case-rating procedure on file with the director.

(7-1-93)

03. Approval Period of Deviated Rates.

(7-1-93)

a. A deviated rate will be in effect for a period of time not longer than the experience period used to establish such rate (i.e. one (1) year, two (2) years or three (3) years). An insurer may file for a new rate before the end of a rate period, but not more often than once during any twelve-month (12) period.

(7-1-93)

b. Notwithstanding the provision of Subsection 019.01 of this rule chapter, if an account changes insurers, that rate approved to be used for the account by the prior insurer is the maximum rate that may be used by the succeeding insurer for the remainder of the rate approval period approved for the prior insurer or until a new rate is approved for use on such account, if sooner.

(7-1-93)

04. Use of Rates Lower Than Filed Rates. An insurer may at any time use a rate for an account that is lower than its filed rate without prior notice, justification and approval by the director.

(7-1-93)

05. Glossary of Terms and Definitions as Used in Section 019.

(7-1-93)

a. "Experience" means "earned premiums" and "incurred claims" during the experience period.

(7-1-93)

b. "Experience Period" means the most recent period of time for which experience is reported, but not for a period longer than three (3) full years.

(7-1-93)

c. "Incurred Claims" means total claims paid during the experience period, adjusted for the change in claim reserve.

(7-1-93)

020. SUPERVISION OF CREDIT INSURANCE OPERATIONS.

01. Responsibilities of Insurer. Each insurer transacting credit insurance in this state shall be responsible for the settlement, adjustment and payment of all claims and shall also be responsible for conducting a

thorough periodic review of creditors with respect to their credit insurance business with such creditors, to assure compliance with the insurance laws of this state and the rules promulgated by the director. Such review shall include, but not be limited to, a verification of the accuracy of premium payments or other identifiable charges, premium refunds, and claims incurred. (7-1-93)

02. Maintenance of Records. Records of such reviews shall be maintained for four (4) years for review by the director. (7-1-93)

021. PROHIBITED TRANSACTIONS.

The following practices, when engaged in by insurers in connection with the sale or placement of credit insurance, or as an inducement thereto, shall constitute unfair methods of competition and shall be subject to the Unfair Trade Practices Act of this State as outlined in Chapter 13, Title 41, Idaho Code. (7-1-93)

01. Special Advantages or Services. The offer or grant by an insurer to a creditor of any special advantage or any service not set out in either the group insurance contract or in the agency contract, other than the payment of producer commissions. (5-8-09)

02. Deposit by Insurer of Money or Securities Required of Creditor. Agreement by an insurer to deposit with a bank or financial institution money or securities of the insurer with the design or intent that the same shall affect or take the place of a deposit of money or securities which otherwise would be required of the creditor by such bank or financial institution as a compensating balance or offsetting deposit for a loan or other advancement. (7-1-93)

03. Deposit by an Insurer Without Interest or at a Lessor Rate of Interest. Deposit by an insurer of 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 and terms. This paragraph shall not be construed to prohibit the maintenance by an insurer of such demand deposits or premium deposit accounts as are reasonably necessary for use in the ordinary course of the insurer's business. (7-1-93)

022. PRODUCER'S LICENSE REQUIRED.

01. Life and Disability Insurance License or Limited License. To solicit credit life and credit disability insurance as provided in Chapter 23, Title 41, Idaho Code, and in this rule chapter, a producer must: (5-8-09)

a. Be licensed to sell life and disability insurance in compliance with Chapter 10, Title 41, Idaho Code; or (7-1-93)

b. Be issued a "Limited License" as defined in Section 41-1003(4), Idaho Code, covering only credit life and credit disability insurance, and no individual so licensed shall during the same period hold a license as a producer as to any other or additional major line of insurance. (5-8-09)

02. Individual, Firm or Corporation. Sections 41-1004, 41-1005, 41-1007, Idaho Code, provide that a limited producer's limited license for credit life and credit disability insurance shall be issued to individuals, firms or corporations qualifying for such license. Any individual who sells, solicits or negotiates with debtors to purchase individual credit life or credit disability insurance, or who explains such coverage, must be licensed as an insurance producer. Any firm or corporation offering such individual coverage must comply with the provisions of Section 41-1007(2) by having a designated licensed producer, who is an individual responsible for the business entity's compliance with the insurance laws and rules of this state. (5-8-09)

03. Administration of Group Policy. Under Section 41-1005(2)(b), Idaho Code, the issuance of group certificates of credit life insurance and credit disability insurance and the performance of other ministerial duties in connection with group insurance policy administration does not require the person doing such acts to be licensed as a producer provided that no commission is paid for such services. A group policyholder may be reimbursed its expense of administering a group policy without being licensed as a producer, and such reimbursement will not be considered a commission provided it is reasonably computed to equate to the actual administrative expenses. It will be presumed that an amount of reimbursement not exceeding ten percent (10%) of the net written prima facie premium for the

group policy is reasonably computed to equate to the administrative expenses of the group policyholder. Amounts exceeding ten percent (10%) of the net written prima facie premium will be presumed to exceed actual administrative expenses unless prior approval to pay such greater amount is secured pursuant to the insurer demonstrating to the director's satisfaction that such higher amount does not exceed the policyholder's actual administrative expenses. For purposes of this subsection, "prima facie premium" means premiums at the rates set forth in Section 014 without adjustment pursuant to Section 018. (5-8-09)

04. Dividends and Other Compensation Permitted by Law. Subsections 022.01, 022.02, and 022.03 do not apply to compensation that is otherwise permitted by law, such as the payment of dividends on participating policies. (7-1-93)

023. DISCLOSURE.

When a premium or identifiable charge is payable by a debtor for credit insurance coverage offered by a creditor, at the time such insurance is applied for, disclosures shall be made to the principal debtor and copies given and retained, in accordance with State and Federal law. The creditor shall also disclose the optional nature of the coverage, premium or identifiable charge separately by type of coverage, eligibility requirements, and policy limitations and exclusions. These disclosures shall be made prominently above the space for the signature indicating election to obtain such coverage. These disclosures may be made in conjunction with either (1) the Federal Truth-in-Lending disclosure, (2) a Notice of Proposed Insurance, or (3) the insurance policy or certificate. (7-1-93)

024. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 01**

18.04.01 – HEALTH CARRIER EXTERNAL REVIEW

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the director under Title 41, Chapters 2 and 59, Idaho Code. (4-7-11)

001. TITLE AND SCOPE.

01. Title. This rule is titled Idaho Department of Insurance Rule IDAPA 18.04.01, “Health Carrier External Review.” (4-7-11)

02. Scope. This rule sets forth uniform requirements to be followed by health carriers and independent review organizations in implementing external review procedures in accordance with Title 41, Chapter 59, Idaho Code. (4-7-11)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (4-7-11)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (4-7-11)

004. INCORPORATION BY REFERENCE.

No documents are incorporated by reference. (4-7-11)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-7-11)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-7-11)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (4-7-11)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-7-11)

007. -- 009. (RESERVED)

010. DEFINITIONS.

As used in this rule, the following terms have the following meanings. (4-7-11)

01. Covered Person. A person as defined in Section 41-5903, Idaho Code. (4-7-11)

02. Director. The director of the Idaho Department of Insurance. (4-7-11)

03. Health Benefit Plan. A plan as defined in Section 41-5903, Idaho Code, and subject to Section 41-5904, Idaho Code. (4-7-11)

04. Health Carrier. An entity as defined in Section 41-5903, Idaho Code. (4-7-11)

05. URAC. The nationally recognized private health care accreditation organization based in Washington, D.C., that accredits independent review organizations. The website for URAC is <http://www.urac.org>. (4-7-11)

011. FONT SIZE FOR PRINTED MATERIALS.

Pertinent text of all printed materials required to be filed with the Director under Title 41, Chapter 59, Idaho Code, or required by this rule, including, but not limited to, notices, disclosure forms and contract forms, is required to be formatted using at least a ten (10) point font. (4-7-11)

012. -- 019. (RESERVED)

020. NOTICE OF RIGHT TO EXTERNAL REVIEW.

01. Disclosure to Covered Persons. Each health carrier must provide a summary description of external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage the health carrier provides to covered persons. Health carriers must use the summary description in Appendix A or one that in the discretion of the Director is substantially identical. This summary description in Appendix A has been approved by the Director as meeting the requirements of Section 41-5916, Idaho Code, and this rule. Health carriers must submit summary description forms to the Director for review. (3-29-12)

02. Notice to Covered Person. When a health carrier sends written notice to a covered person of a final adverse benefit determination, the health carrier must send written notice at the same time of the covered person's right to request an external review. (3-29-12)

a. The written notice of the covered person's right to request an external review must use the form set forth in Appendix B or one that in the discretion of the Director is substantially identical. The notice form in Appendix B has been approved by the Director as meeting the requirements of Section 41-5905, Idaho Code, and this rule. Health carriers must submit notice forms to the Director for review. (3-29-12)

b. The written notice sent by the health carrier as required by this subsection must include an authorization form to disclose protected health information in compliance with the federal regulation 45 CFR section 164.508. Health carriers must submit authorization forms to the Director for review. (3-29-12)

021. REQUEST FOR EXTERNAL REVIEW.

01. Request Form. The form for a covered person to request an external review will be available from the department and will be posted on the department's web site. (4-7-11)

02. Authorization Form. The covered person's request for an external review must include an authorization form to disclose protected health information required in Paragraph 020.02.b. The department will not act on an external review request until the department receives the applicable form completed by the covered person or the covered person's authorized representative. (3-29-12)

03. Appointment of an Authorized Representative. A covered person may name another person, including the treating health care provider, to act as the covered person's authorized representative for an external review request. (4-7-11)

022. HEALTH CARRIER NOTICE OF INITIAL DETERMINATION OF AN EXTERNAL REVIEW REQUEST.

Health carriers must use the form set forth in Appendix C or one that in the discretion of the Director is substantially identical for notice of initial determination by a health carrier for a standard external review required by Section 41-5908, Idaho Code, and for an expedited external review required by Section 41-5909, Idaho Code. Health carriers must submit notice forms to the Director for review. (3-29-12)

023. APPROVAL OF INDEPENDENT REVIEW ORGANIZATIONS.

01. Accreditation. An independent review organization must be accredited by a nationally recognized private accrediting entity in order for the independent review organization to be approved to perform reviews under Title 41, Chapter 59, Idaho Code, and this rule. As of the effective date of this rule, URAC is the only such entity. The Director may later designate other such entities that meet the department's standards set by law and this rule.(4-7-11)

02. Application Required for Registration. Independent review organizations must apply to the department and pay the applicable fees as set forth at IDAPA 18.01.44, "Schedule of Fees, Licenses and Miscellaneous Charges," to be registered to perform external reviews. The application for registration is posted on the department's web site. The application must include the independent review organization's schedule of costs and fees for performing external reviews. (4-7-11)

03. Notice to Director. (4-7-11)

a. An independent review organization must notify the Director in writing within thirty (30) days of the date the independent review organization is no longer accredited by a nationally recognized private accrediting entity or no longer satisfies the minimum requirements established under Title 41, Chapter 59, Idaho Code and this rule. (4-7-11)

b. Any change in the independent review organization's schedule of costs and fees for performing external reviews must be submitted to the Director at least sixty (60) days before the effective date of the change. No such change may be applied to an external review being performed by the independent review organization at the time the change would otherwise take effect. (4-7-11)

04. Termination of Approval. The Director may immediately terminate approval of an independent review organization if the independent review organization is no longer accredited by a nationally recognized private accrediting entity or if the independent review organization no longer satisfies the requirements of Title 41, Chapter 59, Idaho Code and this rule. Notice of termination will be in writing to the independent review organization and such organization will be deleted from the list of organizations approved to perform external reviews. If the independent review organization is performing an external review at the time of termination, the independent review organization must cease performing that review and immediately forward all information and documentation to the Director. (4-7-11)

024. VOLUNTARY ELECTION BY ERISA PLAN ADMINISTRATOR.

01. Written Notice and Compliance. If a single employer self-funded ERISA employee benefit plan administrator or designee voluntarily elects to comply with Title 41, Chapter 59, Idaho Code, the administrator or designee must: (3-29-12)

a. Provide timely and appropriate written notice to the Director of such election. The written notice must include the name of the administrator or designee, the contact name and title of the person to receive correspondence for the administrator or designee, that person's email address, voice and facsimile numbers, and the name of the employer or plan; (3-29-12)

b. Provide written notice to the plan beneficiary of any final adverse benefit determination and of the beneficiary's right to an external review pursuant to Title 41, Chapter 59, Idaho Code, as required by Subsection 020.02 of this rule; and (3-29-12)

c. Comply with all other provisions of Title 41, Chapter 59, Idaho Code, and this rule, as if it were a health carrier, except the administrator or designee is not required to submit for the Director's review the forms attached to this rule as appendices. (3-29-12)

02. Single Plan Beneficiary. The written notice to the Director required in Subsection 024.01 of this rule for a single plan beneficiary must be included with the notice of initial determination of an external review request in Section 022. The notice must include the plan beneficiary's name and identification number. The administrator or designee may not request the Director terminate an external review for a single plan beneficiary

while the review is in progress unless the administrator or designee has reversed the final adverse benefit determination and has notified the beneficiary it will pay benefits for the disputed service or supply. (3-29-12)

03. Specific Period of Time. The written notice to the Director required in Subsection 024.01 for a specific period of time must include the start date and end date for that period of time. The notice must be received by the Director at least thirty (30) days in advance of the date the specific period of time will begin. Any change in the start or end date for a specific period of time on file with the Director must be received in writing at least thirty (30) days in advance of the date the change will take effect. The termination of the specific period of time will not terminate an external review in progress unless the administrator or designee has reversed the final adverse benefit determination and has notified the beneficiary it will pay benefits for the disputed service or supply. (3-29-12)

04. Effect of Election. Any single employer self-funded ERISA employee benefit plan administrator or designee that voluntarily elects to comply with Title 41, Chapter 59, Idaho Code, and this chapter of rules, does not, solely by such election and/or compliance, waive any rights, remedies, duties, causes of action, or defenses it otherwise has under ERISA or other applicable law. (3-29-12)

025. -- 999. (RESERVED)

APPENDICES:

- A Health Carrier Disclosures - "Your Right to an Independent External Review"
- B Health Carrier Notice - "Notice of Your Right to an Independent External Review"
- C Health Carrier's Notice of Initial Determination

Appendix A

The summary description below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5916. A health carrier may change the terms "you, your" to "covered person" and "we, our" to the health carrier's name, or similar references consistent with the health carrier's typical terminology.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or

Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request

qualifies as an “urgent care request” defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

See the department’s website at <http://www.doi.idaho.gov>, or
Call the department’s telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed “Appointment of an Authorized Representative” form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department’s notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written “urgent care request” with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

“Urgent care request” means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your

request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix B

The notice below provides an acceptable format approved by the director as meeting the requirements of Idaho Code Section 41-5905. A health carrier may change the terms “you, your” to “covered person” and “we, our” to the health carrier’s name, or similar references consistent with the health carrier’s typical terminology.

NOTICE OF YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) -- see below under “Binding Nature of the External Review Decision” for more information.

We have denied your request to provide or pay for a health care service or supply. You may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

No later than four months from the date of this denial, you may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

- See the department's website at <http://www.doi.idaho.gov>, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require for review to reach a decision on the external review. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our decision will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department **within four months** after the date we issued this notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"**Urgent care request**" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent

to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: *[NOTE TO HEALTH CARRIERS: The carrier must include one of the applicable paragraphs below for the covered person's health benefit plan.]*

[Your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees). The external review decision by the independent review organization will be final and binding on the health insurer, but you may have additional review rights provided under federal ERISA laws.]

*[The external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review of your claim, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of your claim after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.]*

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

Appendix C

HEALTH CARRIER'S NOTICE OF INITIAL DETERMINATION

[Date]

[Covered Person/Authorized Representative]

[Address]

RE: Initial Determination of Your Request for an External Review

We completed our preliminary review of your request for an external review sent to us by the Idaho Department of Insurance. As part of our review, we considered:

1. Eligibility of the covered person under the health benefit plan at the time the health care service was requested, or, for a post-service review, the health care service was performed;
2. If the health care service is a covered service under the health benefit plan, except for our determination the health care service does not meet our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or the service or supply is investigational;
3. If the covered person has exhausted our internal grievance process, or if we failed to provide a timely determination for a grievance under that process; or if we waived the exhaustion requirement under that process; or if we failed to strictly follow our duties in affording a timely, full and fair opportunity for you to take advantage of that grievance process; or if the request qualifies as an urgent care request and you've simultaneously applied for an expedited internal review; and
4. All information and forms required to process an external review, including your signed authorization to disclose protected health information.

[If the request is complete and eligible for review:

We determined your request is complete and eligible for external review. We sent a copy of this notice to the Idaho Department of Insurance. The Department of Insurance will assign an independent review organization to perform the review and will notify you of the name of that organization.]

[OR if the request is not complete:

We have determined your request is not complete. In order to complete your request, you must provide the following: *(Provide details of what information or materials are needed to make the request complete.)*

[OR if the request is not eligible for external review:

We have determined your request is not eligible for external review. Your request is ineligible for the following reasons: *(Provide details of the reasons for denial.)*

If you disagree with our initial determination that your request is ineligible, you may file a written appeal with the Director of the Idaho Department of Insurance within 30 days of the date of this notice. Your appeal must include adequate detail and documentation to show proof of your eligibility. The Director may determine a request is eligible based on the terms and conditions of the covered person's health benefit plan and the applicable provision of Idaho Code, Title 41, Chapter 59.]

[Include the following for all notices:]

For further information, please contact the Idaho Department of Insurance, (208) 334-4250, or toll-free, 1-800-721-3272. The department's fax number is (208) 334-4398. The department's website is <http://www.doi.idaho.gov>.

Sincerely,

[Health Carrier]

C: Idaho Department of Insurance/External Review

**IDAPA 18
TITLE 04
CHAPTER 02**

**18.04.02 – RULE TO IMPLEMENT UNIFORM COVERAGE FOR
NEWBORN AND NEWLY ADOPTED CHILDREN**

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (4-2-08)

001. TITLE AND SCOPE.

01. Title. This Rule is titled IDAPA 18.04.02, “Rule to Implement Uniform Coverage for Newborn and Newly Adopted Children.” (4-2-08)

02. Scope. This rule sets forth uniform requirements to be followed by health plans providing coverage to newborn and newly adopted children in accordance with Sections 41-2140, 41-2210, 41-3437, 41-3923, 41-4023 and 41-4123, Idaho Code. (4-2-08)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (4-2-08)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (4-2-08)

004. INCORPORATION BY REFERENCE.

There are no documents incorporated by reference. (4-2-08)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-2-08)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-2-08)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (4-2-08)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (4-2-08)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-2-08)

007. -- 009. (RESERVED)

010. DEFINITIONS.

As used in this chapter the following terms have the following meanings. (4-2-08)

01. Congenital Anomaly. Means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purposes of this chapter, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies. (4-2-08)

02. Health Plan. Means any type of benefit plan or contract of coverage that is subject to the requirements of Sections 41-2140, 41-2210, 41-3437, 41-3923, 41-4023 or 41-4123, Idaho Code. (4-2-08)

03. Health Plan Member. Means a person entitled to benefits as a member, subscriber or insured under a health plan and who, under the terms of the health plan contract, may add dependents for coverage under the health plan. (4-2-08)

04. Newborn Child. “Newborn child” means: (4-2-08)

a. A child born to a health plan member and added to the health plan as a newborn dependent in accordance with the terms of the health plan contract; or (4-2-08)

b. An adopted newborn child placed with the adopting health plan member within sixty (60) days of birth and added to the adopting health plan member’s health plan as a newborn dependent in accordance with the terms of the health plan contract. (4-2-08)

05. Newly Adopted Child. Means a child under the age of 18 who is placed with the adopting health plan member more than sixty (60) days after the child’s birth and added to the adopting health plan member’s health plan as a dependent in accordance with the terms of the health plan contract. (4-2-08)

06. Placed. Means physical placement in the care of the adopting health plan member. If physical placement is prevented due to the medical needs of the child, “placed” means the date the adopting health plan member signs an agreement for adoption of the child and assumes financial responsibility for the child. (4-2-08)

011. COVERAGE REQUIREMENTS.

01. Coverage of Newborn and Newly Adopted Children. A health plan subject to this chapter shall provide coverage to: (4-2-08)

a. A newborn child of a health plan member from the moment of birth; or (4-2-08)

b. A newly adopted child of a health plan member from the date the child is placed with the adopting health plan member. (4-2-08)

02. Coverage Requirements. Coverage of newborn and newly adopted children shall be at least equivalent to the coverage afforded other health plan members under the health plan and shall also include, but not be limited to, coverage for the medically necessary care and treatment of congenital anomalies. (4-2-08)

03. Pre-Existing Conditions. A health plan may not apply a pre-existing condition exclusion to a newborn or newly adopted child. (4-2-08)

04. Cosmetic Surgery. A health plan may not exclude as cosmetic surgery reconstructive surgery for congenital anomalies of a covered dependent child entitled to congenital anomaly coverage under this chapter. (4-2-08)

05. Limitations on Coverage for Congenital Anomalies. A health plan may apply exclusions, requirements or benefit limitations, including cost sharing requirements, to coverage for congenital anomalies that are consistent with the requirements of this rule and no more restrictive than exclusions, requirements or benefit limitations applied to coverage for similar treatments, conditions and services provided under the health plan. (4-2-08)

012. NOTIFICATION AND PAYMENT REQUIREMENTS.

01. Notification and Payment. (4-2-08)

a. If notice and payment of additional premium are required for dependent coverage under the health

plan contract, the contract may require notice of birth, placement or adoption and payment of required premium as a condition of coverage for newborn and newly adopted children. The notification period shall be not less than sixty (60) days from the date of birth for a newborn child or, for newly adopted children, sixty (60) days from the earlier of the date of adoption or placement for adoption. The due date for payment of any additional premium, if required, shall be not less than thirty-one (31) days following receipt by the health plan member of a billing for the required premium. (4-2-08)

b. All requirements for notice and payment of premium applied by the health plan for the enrollment of newborn or newly adopted children shall be clearly set forth in the health plan contract and provided to the health plan members in a manner reasonably calculated to provide notice to the members of the requirements. (4-2-08)

c. If the health plan member fails to provide the required notification, or make the required premium payment, the health plan may decline to enroll a dependent child as a newborn or newly adopted child, but shall treat a newborn or newly adopted child no less favorably than it treats other applicants who seek coverage at a time other than when the applicant was first eligible to apply for coverage. (4-2-08)

d. For self-funded health care plans subject to Chapter 40 or 41, Title 41, Idaho Code, any references to premium in Section 012 of this rule should be recognized to be applying to contributions. (4-11-19)

013. PORTABILITY.

The coverage provided by this chapter applies to any subsequent health plan that is issued providing coverage to the newborn or newly adopted child. If there is a break in coverage that exceeds sixty-three (63) days, the health plan may treat a congenital anomaly as a pre-existing condition and apply pre-existing condition exclusions as allowed under the applicable state and federal laws. (4-2-08)

014. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 03**

18.04.03 – ADVERTISEMENT OF DISABILITY (ACCIDENT AND SICKNESS) INSURANCE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapters 2 and 13, Idaho Code. (3-30-07)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.04.03, “Advertisement of Disability (Accident and Sickness) Insurance.” (3-30-07)

02. Scope. The purpose of these rules is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance, including Medicare supplement accident and sickness insurance and long term care insurance. 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 (accident and sickness) insurance in a manner that prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-30-07)

004. INCORPORATION BY REFERENCE.

There are no documents to be incorporated by reference. (3-30-07)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)

04. Web Site Address. The Department’s website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. APPLICABILITY.

01. Disability and Medicare Supplement Insurance. These rules apply to any disability (accident and sickness) insurance “advertisement,” including Medicare supplement and long term care insurance “advertisement,” as that term is hereinafter defined, 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 or producer as those terms are defined in the Insurance Code of this state and these rules. (3-30-07)

02. Control over Advertisement. 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 whose policies are so advertised. (7-1-93)

008. -- 009. (RESERVED)

010. DEFINITIONS.

01. Advertisement. An advertisement for the purpose of these rules includes: (7-1-93)

a. Printed and published material, audio visual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio scripts, TV scripts, web sites and other internet displays or communications, other forms of electronic communications, billboards and similar displays; and (3-30-07)

b. Descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and (3-30-07)

c. Prepared sales talks, presentations and material for use by producers whether prepared by the insurer or the producer. (3-30-07)

02. Policy. "Policy" for the purpose of these rules includes any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. The term includes contracts for Medicare supplement insurance and long term care insurance. (3-30-07)

03. Insurer. "Insurer" for the purpose of these rules includes any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity that is defined as an "insurer" in the Insurance Code of this state and is engaged in the advertisement of a policy as "policy" is herein defined. (7-1-93)

04. Exception. "Exception" for the purpose of these rules means 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. (7-1-93)

05. Reduction. "Reduction" for the purpose of these rules means any provision that 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. (7-1-93)

06. Limitation. "Limitation" for the purpose of these rules any provision that restricts coverage under the policy other than an exception or a reduction. (7-1-93)

011. 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 statements 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. (7-1-93)

012. FORM AND CONTENT OF ADVERTISEMENTS.

01. Format and Content. The format and content of an advertisement of an accident or sickness insurance policy 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

Director of Insurance 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. (7-1-93)

02. Truthful and Clear. 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. (7-1-93)

013. ADVERTISEMENTS OF BENEFITS PAYABLE, LOSSES COVERED OR PREMIUMS PAYABLE.

01. Prohibitions. Deceptive Words, Phrases Or Illustrations Prohibited: (7-1-93)

a. 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. (7-1-93)

b. 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 that exaggerates any benefits beyond the terms of the policy. (7-1-93)

c. 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 pre-existing 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. (7-1-93)

d. 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 “tax free”; “extra cash”; “extra income”; “extra pay”; or substantially similar words or phrases in such a manner as to 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. (7-1-93)

e. No advertisement of a hospital or other similar facility 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. (7-1-93)

f. No advertisement of a policy covering only one (1) 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. (7-1-93)

g. 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.” (7-1-93)

h. 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. (7-1-93)

i. No advertisement shall contain or use words or phrases such as, “Medicare supplement”; “Medigap”; “this policy will help fill some of the gaps that Medicare leaves out”; or similar words and phrases, unless the policy is issued in compliance with IDAPA 18.01.54, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.” (7-1-93)

j. An advertisement must state clearly the type of insurance coverage being offered. (3-30-07)

02. Exceptions, Reductions and Limitations. (7-1-93)

a. When an advertisement 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. (7-1-93)

b. 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 that is subject to the requirements of the preceding paragraph shall disclose the existence of such periods. (7-1-93)

c. An advertisement shall not use the words “only”; “just”; “merely”; “minimum”; or similar words or phrases to describe the applicability of any exceptions and reductions, such as: “This policy is subject to the following minimum exceptions and reductions.” (7-1-93)

03. Pre-Existing Conditions. (7-1-93)

a. An advertisement that is subject to the requirements of Subsection 013.02 shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The term “pre-existing condition” without an appropriate definition or description shall not be used. (3-30-07)

b. When a policy does not cover losses resulting from pre-existing 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 a similar import, but does not prohibit explaining “automatic issue.” If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required. (7-1-93)

c. 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 or statement that reflects the pre-existing 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 or statement 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 that you now have or have had in the past?” _____ YES. Or substantially the following statement: “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 that I now have or have had in the past.” (7-1-93)

014. NECESSITY FOR DISCLOSING POLICY PROVISIONS RELATING TO RENEWABILITY, CANCELLATION AND TERMINATION.

When an advertisement 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, cancellation and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner that shall not minimize or render obscure the qualifying conditions. (7-1-93)

015. TESTIMONIALS OR ENDORSEMENTS BY THIRD PARTIES.

01. Testimonials. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial,

makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules. (7-1-93)

02. Disclosure of Financial Interest. 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 TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation. (7-1-93)

03. Limitations and Restrictions. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any 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. (7-1-93)

04. Retention of Data. 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 (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. (7-1-93)

016. USE OF STATISTICS.

01. Requests for Use of Statistical Information. 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. (7-1-93)

02. Restrictions on Representations. 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 a unique claim for the policy advertised is misleading and shall not be used. (7-1-93)

03. Source of Statistics. The source of any statistics used in an advertisement shall be identified in such advertisement. (7-1-93)

017. IDENTIFICATION OF PLAN OR NUMBER OF POLICIES.

01. Disclosure Requirements. When a choice of the amount of benefits is referred to, an advertisement 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. (7-1-93)

02. Disclosure Based on Combination of Policies. When an advertisement refers to various benefits that may be contained in two (2) or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies. (7-1-93)

018. 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. (7-1-93)

019. JURISDICTION LICENSING AND STATUS OF INSURER.

01. Restrictions on Licensing Jurisdiction. An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. (7-1-93)

02. Restrictions on Endorsements. 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. (7-1-93)

020. IDENTITY OF INSURER.

01. Name of Insurer to Be Identified. The name of the actual insurer shall be clearly identified and the policy or policies advertised shall be identified by form number or otherwise described, so as to clearly identify the product being advertised. 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 that, without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer. (7-1-93)

02. Identity of Insurer Not to Be Misrepresented. No advertisement shall use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color or other characteristics are so similar to combinations 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. (7-1-93)

021. 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. (7-1-93)

022. INTRODUCTORY, INITIAL OR SPECIAL OFFERS.

01. Restrictions on Introductory, Initial or Special Offers. (7-1-93)

a. 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 accident and sickness insurance. (7-1-93)

b. 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 (3) 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 that shall be not less than ten (10) days and not more than forty (40) 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 (1) insurer. It is inapplicable to solicitations of employees or members of a particular group or association that otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase “any one (1) insurer” includes all the affiliated companies of a group of insurance companies under common management or control. (7-1-93)

c. 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. (7-1-93)

d. The phrase “a particular insurance product” in paragraph(s) of this Section means an insurance policy that provides substantially different benefits than those contained in any other policy. Different terms of renewability; and increase or decrease in the dollar amounts of benefits; and 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 concurrent or overlapping enrollment periods. (7-1-93)

02. Restrictions on Reduced Initial Premium. An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that 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. (7-1-93)

03. Restriction on Special Awards. Special awards, such as a “safe drivers’ award” shall not be used in connection with advertisements of accident or accident and sickness insurance. (7-1-93)

023. STATEMENTS ABOUT AN INSURER.

An advertisement shall not contain statements that 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. (7-1-93)

024. ENFORCEMENT PROCEDURES.

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 other state, with a notation attached to each such advertisement that 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 this Department. All such advertisements shall be maintained in said file for a period of either four (4) years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time. (3-30-07)

025. FILING FOR PRIOR REVIEW.

The Director may, at his discretion, require the filing of any accident and sickness insurance advertising material for review prior to use. Such advertising material must be filed by the insurer with this Department not less than thirty (30) days prior to the date the insurer desires to use the advertisement. (4-11-19)

026. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 04**

18.04.04 – RULE TO IMPLEMENT THE MANAGED CARE REFORM ACT

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapter 39, Title 41, Idaho Code. (7-1-98)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.04, “Rule to Implement the Managed Care Reform Act.” (7-1-98)

02. Scope. The Act and this rule are intended to define procedures to be followed in establishing and operating a Managed Care Organization; to define how certain of the powers of the Managed Care Organization shall be exercised; to define certain required reserves or liabilities; to establish requirements of certain reports and general disclosures to be furnished to the Director; and to establish rules pertaining to an organized system of health care providers, or those providers who willingly accept referrals through the managed care organization. (7-1-98)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost at this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (7-1-98)

004. DEFINITIONS.

01. The Act. All terms defined in the Act that are used in this rule have the same meaning as used in the Act. (7-1-98)

02. Balance Billing. An organized system of health care providers and providers who accept referrals from the Managed Care Organization are prohibited from balance billing individuals. Balance billing refers to the practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. (7-1-98)

03. Director. The term, Director, as referred to in this rule, shall mean the Director of the Department of Insurance, State of Idaho. (7-1-98)

04. MCO. Managed Care Organizations is abbreviated to MCO in this rule. (7-1-98)

05. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or otherwise authorized to furnish health care services. (7-1-98)

005. -- 010. (RESERVED)

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority Required. Any person offering a managed care plan on a predetermined and prepaid basis is transacting the business of insurance and must be authorized under a Certificate of Authority issued by the Director of Insurance. (7-1-98)

02. Availability of Forms. Application forms will be furnished by the Director on the request of the MCO. (7-1-98)

03. Application Requirements. The application for a Certificate of Authority will include the additional affidavits, statements, and other information as enumerated in Idaho Code, Sections 41-319, 41-3904, 41-3905, and 41-3906. After receiving these completed documents, the Director has the authority to request any supplemental information he deems necessary before final approval or disapproval is given. (7-1-98)

04. Capital Surplus and Deposit Requirements. In accordance with Idaho Code, Sections 41-3905(8) and 41-3905(9), a managed care organization having a valid Idaho certificate of authority to transact insurance as a health maintenance organization on or before July 1, 1997, or a managed care organization issued a certificate of authority after July 1, 1997, may be allowed by the Director of the Department of Insurance a period of up to three years to comply with the capital, surplus, and deposit requirements of Idaho Code, Sections 41-313 and 41-316 or 41-316A. (7-1-98)

a. The Director has established the following minimum increases in capital fund requirements as per Idaho Code, Section 41-3905(8), based on the number of enrolled members:

Enrolled Members	Capital Funds
0-100	200,000
101-300	300,000
301-500	400,000
501-700	500,000
701-1,000	1,000,000
1,001-2,000	1,500,000
2,001-3,000	2,000,000

(7-1-98)

b. In no event shall the organization's capital funds be less than the following:

One year after the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	\$1,000,000
Two years after the date the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	\$1,500,000
Three years after the date the organization becomes subject to Title 41, chapter 39, as amended effective July 1, 1997:	\$2,000,000

(7-1-98)

c. Immediately upon becoming subject to Title 41, Chapter 39, Idaho Code, as amended effective July 1, 1997, the managed care organization's minimum statutory deposit requirements shall be calculated as fifty percent (50%) of the amount of the organization's Capital funds as calculated above up to a maximum of one million dollars (\$1,000,000), but shall not be less than two hundred thousand dollars (\$200,000). The amount of the deposit so held by the Department shall be adjusted based on the organization's December 31st and June 30th financial statement filings each year. In no event will the minimum required statutory deposit amount be reduced. Upon notification by the department of the necessary increase in the deposit amount, the organization will have no more than thirty (30) days to come into compliance with the required amount. Failure to increase the deposit as required will subject the organization to suspension or revocation of its certificate of authority pursuant to Section 41-326, Idaho Code.

(7-1-98)

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Required. In accordance with Section 4, paragraph (2) of the Act, a proposed MCO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed managed care services. (7-1-98)

02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed MCO shall submit its request for permission to the Director in writing, with copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. (7-1-98)

03. Methods of Solicitation. Advertising and solicitation materials used by a proposed MCO must meet the following minimum requirements: (7-1-98)

a. The prospective enrollee shall clearly be advised that: (7-1-98)

i. The proposed MCO is not as yet authorized to offer health care services in this state; (7-1-98)

ii. Coverage for health care services is not being provided at the time of the solicitation; (7-1-98)

iii. The solicitation is not a guarantee that any services will be provided at a future date. (7-1-98)

b. The format and content of any material offered shall be in conformity with the MCO Act. Such material shall contain but not be limited to the following information: (7-1-98)

i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled; (7-1-98)

ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; (7-1-98)

iii. The predetermined periodic rate of payment for the proposed services; (7-1-98)

iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. (7-1-98)

c. No person shall solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO. (7-1-98)

013. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.

The annual disclosure material required to be filed with the Director pursuant to Section 41-3914(3), Idaho Code, shall be filed with the reports to the Director on or before March 1 each year. (7-1-98)

014. ANNUAL REPORT TO THE DIRECTOR.

In accordance with Sections 41-3910 and 41-335, Idaho Code, every managed care organization shall annually on or before the first day of March, file with the Director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise required by the Director, the statement is to be prepared in accordance with the annual statement instructions and the accounting practices and procedures manual adopted by the National Association of Insurance Commissioners (NAIC) and is to be submitted on the NAIC annual convention blank form. The managed care organization shall also file its annual audited financial report in accordance with IDAPA 18.07.04, "Annual Audited Financial Reports." (7-1-98)

015. PERSONNEL AND FACILITIES LISTING REQUIRED.

01. Current Listing Required. The MCO shall at all times keep a current list of all personnel, providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list shall be available to the Director at his request. (7-1-98)

02. Allowable Expense -- No Balance Billing. No MCO provider or other provider accepting a referral from an MCO, who treats or provides services to an individual covered by the MCO, shall charge to or collect from any member or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the MCO or by the administrator for the MCO. Nothing in this section shall be construed to prevent the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. (7-1-98)

03. Procedures for Basic Care and Referrals. The MCO shall provide basic health care to enrollees through an organized system of health care providers. In plans in which referrals to specialty physicians and ancillary services are required, the MCO provider or the MCO shall initiate the referrals. The MCO shall inform its providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals, including prohibition of balance billing. (7-1-98)

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, shall arrange for covered health care services, including referrals to providers within the organized system of health care providers and noncontracting providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters. (7-1-98)

05. Out of Network Services. In the case of provider care which is delivered outside of the organized system of health care providers or defined referral system, the MCO must alert those covered under health benefit plans to the fact that providers which are not MCO providers, or have not accepted written referrals, may balance bill the customer for amounts above the MCO's maximum allowance. Consumers should be encouraged to discuss the issue with their providers (7-1-98)

016. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 05**

18.04.05 – SELF-FUNDED HEALTH CARE PLANS RULE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (4-5-00)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.05, “Self-Funded Health Care Plans Rule.” (3-25-16)

02. Scope. The purpose of this rule is to supplement the provisions of Title 41, Chapter 40, Idaho Code, Self-Funded Health Care Plans by providing: (4-5-00)

- a.** Dates of application for registration; (4-5-00)
- b.** Requirements for application for registration; (4-5-00)
- c.** Rules regarding investigation of applications; (4-5-00)
- d.** Definition of terms, required liabilities; and establishment of reserve bases; (3-25-16)
- e.** Requirements for contribution rates, contracts and services, and records; and (3-25-16)
- f.** An effective date. (3-25-16)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals shall be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General,” Sections 101 through 400. (3-30-07)

004. INCORPORATION BY REFERENCE.

There are no documents to be incorporated by reference. (3-30-07)

005. OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

- 01. Office Hours.** 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)
- 02. Mailing Address.** P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)
- 03. Street Address.** 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)
- 04. Web Site Address.** The department’s website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

All terms defined in Title 41, Chapter 40, Idaho Code, that are used in this rule have the same meaning as used in that Chapter. (3-25-16)

01. "All Contributions to Be Paid in Advance." As used in Title 41, Chapter 40, Idaho Code, means all contributions are to be paid in advance of the period of time for which the contribution is made. (3-25-16)

02. "Deposited in and Disbursed from a Trust Fund." As used in Title 41, Chapter 40, Idaho Code, means all contributions based on calculated rates in accordance with Section 028 of this rule shall be deposited into the trust fund and all expenses shall be paid out of the trust fund. (3-25-16)

011. -- 020. (RESERVED)

021. QUALIFICATION OF PLAN.

In order for a plan to qualify under Title 41, Chapter 40, Idaho Code, the plan's trust must be established by agreement between the employer or employers or a postsecondary education institution and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the employer or employers or to students of the postsecondary educational institution. (3-25-16)

022. REGISTRATION.

01. Registration Required. No self-funded plan, unless exempted from registration by Section 41-4003(2), Idaho Code, shall be organized and permitted to operate in the state of Idaho without securing a Certificate of Registration from the Director of insurance. (4-5-00)

02. Specific Plans. Any plans covering the employees of a common employer shall be deemed to be a single plan in respect to the exemption for registration allowed in Section 41-4003(2)(a), Idaho Code. Any combinations of plans under the effective control of a single administrator, trustee, and/or employer, or group of administrators, trustees and/or employers utilizing or attempting to utilize the exempt dollar amounts permitted under Section 41-4003(2)(a), Idaho Code in order to avoid registration of any such plans is deemed to be contrary to the intent of Chapter 40, Title 41, Idaho Code, and is expressly prohibited by this rule. (4-5-00)

03. Beneficiary Within State. Registration is required of Plans that cover any beneficiary working or residing within this state, unless the plans are otherwise exempted by Section 41-4003(2), Idaho Code. (3-30-07)

023. (RESERVED)

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.

The Director may make an investigation of matters accompanying the application for registration as deemed necessary including an examination specified in Section 41-4013, Idaho Code. Costs of any investigation and/or examination shall be borne by the trust fund of the plan. (4-5-00)

025. CONTRIBUTIONS RECEIVABLE.

The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. (7-1-93)

026. TRUST FUND RESERVES AND SURPLUS.

01. Reserve Requirements. The trust fund of the plan must continuously maintain reserves sufficient, as certified by a qualified actuary as being necessary, to fully fund payment of all benefits in effect at the time a claim thereunder arises. This reserve must adequately provide for all reasonably estimated future claim payments, adjustment expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any. (3-25-16)

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits shall be in an amount not less than reserves determined by the Minimum Reserve Standards for Group Health Insurance

Contracts set forth the in the NAIC's Accounting Practices and Procedures Manual as adopted by the Director unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified. (3-30-07)

03. Certification by Actuary. Reserves must be certified annually by a qualified actuary. Such certification must be accompanied by a statement describing bases used in reserve determination. The certification shall be in a form acceptable to the Director. (3-25-16)

04. Insolvent Condition. If determination of surplus reveals a deficiency in surplus, the Director may, in his discretion, allow the plan a period of time not exceeding ninety (90) days to accumulate required surplus. The plan shall be deemed to be insolvent when the plan is either unable to pay its obligations when they are due or its assets do not exceed all its liabilities, including required reserves. (3-25-16)

027. BONDING.

01. Certified Copy of Bond. A certified copy of the fidelity bond or equivalent coverage, as required under Section 41-4014(3), Idaho Code, shall be furnished to the Director by the plan. (3-30-07)

02. Scope of Coverage. The fidelity bond or equivalent coverage shall cover every trustee, officer, director, and employee of the plan. (3-25-16)

03. Cancellation of Bond Requirements. The fidelity bond or equivalent coverage must contain language stating that it is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. A copy of any notice cancelling a bond required under Chapter 40, Title 41, Idaho Code, is to be forwarded to the Director by the surety at the same time it is forwarded to the trustee. (3-25-16)

04. Third Party Administrator. Any party that provides any one of the following services to the plan must be licensed as a third party administrator in accordance with Title 41, Chapter 9, Idaho Code, and Section 41-4014(4), Idaho Code: (3-25-16)

- a. Directly or indirectly underwrites; (3-25-16)
- b. Collects or handles charges or contributions; or (3-25-16)
- c. Adjusts or settles claims on members or beneficiaries of the plan. (3-25-16)

028. CONTRIBUTION RATES.

01. Contribution Rate Calculation. Contribution rates shall be calculated at least annually by a qualified actuary. The contribution rate calculations should be broken down and designated as the rate for the employer and the rate per employee, or the rate for the postsecondary educational institution and the rate per student. (3-25-16)

02. Employer Contributions. Employer contributions shall be based on filed rates, paid in advance on a periodic basis during the period of coverage or at the beginning of the period of coverage. (3-25-16)

03. Annual Filing of Rates. The required annual filing of rates with the Director shall include the breakdown as required under Subsection 028.01. (3-25-16)

029. CONTRACTS AND SERVICES.

01. Affiliated Contracts. All contracts for goods or services provided to the plan by any plan sponsor, employer, third party administrator, or other affiliated entity or employee or agent thereof, shall be in writing, setting forth in detail the rights and duties of each party to the writing; regardless of whether compensation, fees, or other consideration is paid or exchanged directly or indirectly. (3-25-16)

02. Contracts for Services. All contracts for services including, but not limited to, accounting services, legal services, custodial agreements, and agreements for lease, rent, or insurance coverage to be performed

or entered into on behalf of the plan shall be directly with the plan as agreed to by the board of trustees and the other party. (3-25-16)

03. Recordkeeping and Writing. Contracts and agreements valued at greater than five hundred dollars (\$500.00) entered into by the plan, shall be in writing and shall be approved by resolution of the board of trustees, and placed in the minutes and records of the plan. (3-25-16)

04. Fiduciary Duty. By entering into contracts and agreements, the trustees are not permitted to transfer or otherwise avoid their statutory fiduciary responsibilities. (3-25-16)

030. RECORDS.

01. Board Actions. Any and all acts, resolutions, appointments, or delegations, or other decisions of the board of trustees shall be in writing and placed in the minutes and records of the plan. (3-25-16)

02. Complete Records. The full and accurate records and accounts of the plan include, but are not limited to, minutes of the meetings of the board of trustees that document the acts, resolutions, appointments or delegations of the trustees; any and all correspondence between the board of trustees and contractors; accounting and actuarial records; and any and all records, correspondence, minutes, or statements as required by law or the trust agreement. (3-25-16)

031. ANNUAL STATEMENT.

The trustee shall file an annual statement within ninety (90) days after the close of each fiscal year of the Plan and at such other time as may be determined by the Director. A quarterly statement shall be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director. (3-30-07)

032. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 06**

18.04.06 – GOVERNMENTAL SELF-FUNDED EMPLOYEE HEALTH CARE PLANS RULE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (3-30-07)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.06, “Governmental Self-Funded Employee Health Care Plans Rule.” (3-30-07)

02. Scope. The purpose of this rule is to supplement the provisions of Title 41, Chapter 41, Idaho Code, Joint Public Agency Self-Funded Health Care Plans by providing: (3-30-07)

- a.** Dates of application for registration; (3-30-07)
- b.** Requirements for application for registration; (3-30-07)
- c.** Rules regarding investigation of applications; (3-30-07)
- d.** Definition of required liabilities; and establishment of reserve bases; and (3-30-07)
- e.** To provide an effective date. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, chapter 52, Idaho Code, and IDAPA 04.11.01, Idaho Rules of Administrative Procedure of the Attorney General, Sections 100 through 400. (3-30-07)

004. INCORPORATION BY REFERENCE.

There are no documents to be incorporated by reference (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

- 01. Office Hours.** 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)
- 02. Mailing Address.** P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)
- 03. Street Address.** 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)
- 04. Web Site Address.** The department’s website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

All terms defined in Title 41, Chapter 41, Idaho Code, that are used in this rule have the same meaning as used in that Chapter. (3-30-07)

011. -- 020. (RESERVED).

021. QUALIFICATION OF PLAN.

In order for a plan to qualify under Title 41, Chapter 41, Idaho Code, the plan's trust must be established by agreement between the public agency employers or joint powers entity and the trustee of the trust, for the sole purpose of providing health care benefits to employees of the public agency employer or employers. (3-30-07)

022. REGISTRATION.

01. Registration Required. No joint public agency self-funded plan, unless exempted from registration by Section 41-4103, Idaho Code, shall be organized and permitted to operate in the state of Idaho without securing a certificate of registration from the Director of insurance. (3-30-07)

02. Beneficiary Within State. Registration is required of plans that cover any beneficiary working or residing within this state, unless the plans are otherwise exempted by Section 41-4103, Idaho Code. (3-30-07)

023. APPLICATION FOR REGISTRATION.

01. Application. The application must include each of the requirements set out in Section 41-4105, Idaho Code. The projected income and disbursement statement referenced in Section 41-4105(2)(d), Idaho Code, must be certified by an actuary meeting the qualifications of Section 41-4105(2)(d), Idaho Code, and accompanied by a description of assumptions used in projecting income and disbursements together with bases used to estimate amounts reserved for claims. (3-30-07)

02. Joint Powers Agreement. The joint powers agreement must comply with Title 41, Chapter 41 and, to the extent not in conflict with Title 41, the joint powers agreement must also comply with Title 67, Chapter 23, Idaho Code. The joint powers agreement must contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. (3-30-07)

03. Trust Agreement. (3-30-07)

a. The trust agreement must comply with Title 41, Chapter 41, Idaho Code and, to the extent not in conflict with Title 41, the trust agreement must also comply with Title 68, Idaho Code, and Title 15, Chapter 7, Idaho Code. The trust agreement must contain, at a minimum, the conditions set forth in Section 41-4104, Idaho Code. (3-30-07)

b. The term irrevocable as used in Section 41-4104(1), Idaho Code, means that the plan sponsor cannot retain a power to alter, amend, revoke or terminate the transfer in trust. The trustee may, pursuant to the terms of the trust agreement, amend the terms of the trust agreement for the purpose of complying with applicable law. (3-30-07)

04. Biographical Affidavit. The application must be accompanied by a biographical affidavit for each trustee on a form acceptable to Director. (3-30-07)

024. INVESTIGATION OF PROPOSED APPLICATION FOR REGISTRATION.

The Director may make an investigation of matters accompanying the application for registration as deemed necessary including an examination specified in Section 41-4113, Idaho Code. (3-30-07)

025. CONTRIBUTIONS RECEIVABLE.

The trust fund may take credit in any financial statement for contributions receivable which are not in excess of ninety (90) days past due. (3-30-07)

026. TRUST FUND RESERVES.

01. Reserve Requirements. The trust fund of a plan not in existence as of July 1, 2006, must continuously maintain reserves, pursuant to Section 41-4110, Idaho Code, from inception of the plan, that are sufficient to fully fund payment of all benefits at the time a claim thereunder arises. This reserve must adequately provide for all reasonably estimated future claim payments, adjustment expenses, and litigation expenses on claims which have arisen, including claims incurred but not reported, extended benefits and maternity benefits, if any.

(3-30-07)

02. Reserves for Disability Income Benefits. Reserves established for disability income benefits shall be in an amount not less than reserves determined by the Minimum Reserve Standards for Group Health Insurance Contracts set forth in the NAIC's Accounting Practices and Procedures Manual as adopted by the Director, unless it can be proven to the satisfaction of the Director that a lower reserve can be actuarially justified.

(3-30-07)

03. Certification by Actuary. Reserves must be certified annually by an actuary who meets the requirements of Section 41-4105(2)(d), Idaho Code, and such certification must be accompanied by a statement describing bases used in reserve determination. The certification shall be in a form acceptable to the Director.

(3-30-07)

04. Insolvent Condition.

(3-30-07)

a. For a self-funded plan in existence as of July 1, 2006, three (3) years after the effective date of Chapter 41, if the determination of reserves reveals an insolvent condition, the Director may, in his discretion, allow the plan a period of time not exceeding ninety (90) days to accumulate required reserves.

(3-30-07)

b. For plans formed after July 1, 2006, if the determination of reserves reveals an insolvent condition, the Director may, in his discretion, allow the plan a period of time not exceeding ninety (90) days to accumulate required reserves.

(3-30-07)

05. Insolvency. Insolvency means that the plan is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities, including required reserves.

(3-30-07)

027. BONDING OR DISHONESTY INSURANCE.

01. Certified Copy of Bond. A certified copy of the fidelity bond or dishonesty policy, as required under Section 41-4114(3), Idaho Code, shall be furnished to the Director by the plan.

(3-30-07)

02. Cancellation of Bond Requirements. The bond or dishonesty policy must contain language stating that the bond or policy is noncancellable except upon not less than thirty (30) days advance notice in writing to the trustee and the Director. A copy of any notice cancelling a bond or dishonesty policy required under Chapter 41 is to be forwarded to the Director by the surety or policy provider at the same time it is forwarded to the board.

(3-30-07)

028. ANNUAL STATEMENT.

The trustee shall file an annual statement within ninety (90) days after the close of each fiscal year of the plan and at such other time as may be determined by the Director. A quarterly statement shall be filed with the Director within sixty (60) days of the end of each quarter in a form acceptable to the Director.

(3-30-07)

029. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 07**

18.04.07 – RESTRICTIONS ON DISCRETIONARY CLAUSES IN HEALTH INSURANCE CONTRACTS

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the director under Title 41, Chapters 2, 13 and 18, Idaho Code. (5-8-09)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.07, “Restrictions on Discretionary Clauses in Health Insurance Contracts.” (5-8-09)

02. Scope. This rule sets forth uniform requirements regarding the use of discretionary clauses to be followed by health carriers transacting insurance in Idaho. (5-8-09)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying, at cost, in the main office and each regional or district office of this agency. (5-8-09)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, Idaho Rules of Administrative Procedure of the Attorney General. (5-8-09)

004. INCORPORATION BY REFERENCE.

No documents are incorporated by reference. (5-8-09)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (5-8-09)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (5-8-09)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (5-8-09)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (5-8-09)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (5-8-09)

007. -- 009. (RESERVED).

010. DEFINITIONS.

As used in this rule, the following terms have the following meanings. (5-8-09)

01. Director. “Director” means the Director of the Idaho Department of Insurance. (5-8-09)

02. Discretionary Clause. “Discretionary clause” means any health insurance contract provision that provides the health carrier with sole discretionary authority to determine eligibility for benefits or to interpret the terms and provisions of the health insurance contract. (5-8-09)

03. Health Care Services. “Health care services” means services for the diagnosis, prevention,

treatment, cure or relief of a health condition, illness, injury, or disease. (5-8-09)

04. Health Carrier. “Health carrier” means an entity subject to regulation under Title 41, Chapters 21, 22, 32, 34, 39, 40, 41, 47, 52 or 55, Idaho Code. (5-8-09)

05. Health Insurance Contract. “Health insurance contract” means any policy, contract, certificate, agreement, or other form or document providing, defining, or explaining coverage for health care services that is offered, delivered, issued for delivery, continued, or renewed in this state by a health carrier. For purposes of this rule, “health insurance contract” does not include a contract for group coverage offered by or through an employer to its employees. (5-8-09)

011. DISCRETIONARY CLAUSES.

01. Discretionary Clauses Prohibited. No health insurance contract may contain a discretionary clause. (5-8-09)

02. Required Filing. By the first day of the second month following the effective date of this rule, each health carrier transacting insurance in this state shall submit to the director a list of all health insurance contracts in effect in Idaho that contain discretionary clauses and shall submit a certification that the list is complete and accurate. If a health carrier has no health insurance contracts in effect, the health carrier shall submit a letter to the director reporting and certifying that fact. (5-8-09)

012. GROUNDS FOR DISAPPROVAL.

Any health insurance contract containing terms inconsistent with the provisions of this rule is misleading, inequitable and unfairly prejudicial to the policyholder and the insurance-buying public. In addition to any other sanction or remedy afforded by Title 41, Idaho Code, the use of provisions inconsistent with this rule in a health insurance contract shall be grounds for the director to disapprove the health insurance contract in accordance with Section 41-1813, Idaho Code. (5-8-09)

013. -- 999. (RESERVED).

**IDAPA 18
TITLE 04
CHAPTER 08**

**18.04.08 – INDIVIDUAL DISABILITY AND GROUP SUPPLEMENTAL DISABILITY
INSURANCE MINIMUM STANDARDS RULE**

000. LEGAL AUTHORITY.

This rule is issued pursuant to the authority vested in the Director under Chapter 42, Title 41, Idaho Code, and Chapter 52, Title 67-5220(1), Idaho Code. (3-30-01)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.08, “Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule.” (3-30-01)

02. Scope. The purpose of this rule is to implement Chapter 42, Title 41, Idaho Code, and, to this extent not in conflict with federal law, to standardize and simplify the terms and coverages of individual disability insurance policies, and group supplemental health insurance consisting of group disability policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage. This rule is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims, and to provide for full disclosure in the marketing and sale of individual accident and sickness insurance policies and group supplemental health insurance. This rule is also intended to provide for disclosure in the sale of dental and vision plans. (3-30-01)

03. Application. This rule applies to all individual accident and sickness insurance policies and group supplemental health policies and certificates, including short-term plans, delivered or issued for delivery in this state on and after the effective date of this rule that are not specifically exempted from the rule. (3-30-01)

a. This rule applied to dental plans and vision plans only as specified. (3-30-01)

b. This rule does not apply to: (3-30-01)

i. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this rule. (3-30-01)

ii. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this rule. (3-30-01)

iii. Medicare supplement policies subject to Chapter 44, Title 41, Idaho Code, Medicare Supplement Insurance Minimum Standards, and IDAPA 18.04.10, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.” (3-30-01)

iv. Long-term care insurance policies subject to Chapter 46, Title 41, Idaho Code, Long Term Care Insurance, and IDAPA 18.04.11, “Long-Term Care Insurance Minimum Standards.” (3-30-01)

v. Civilian Health and Medical Program of the Uniformed Services, Chapter 55, Title 10 of the United States Code, (CHAMPUS) supplement insurance policies. (3-30-01)

04. Other Rules Applicable. The requirements contained in this rule shall be in addition to any other applicable rules previously adopted. (3-30-01)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter.

These documents will be available for public inspection and copying at cost at this agency. (3-30-01)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-30-01)

004. INCORPORATION BY REFERENCE.

01. Copies. Copies of these documents may be obtained from the Idaho Department of Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, Idaho 83702-0043, or from the Internet website at <http://www.doi.idaho.gov/> under the “Consumer Assistance” link. (3-30-01)

02. Documents Incorporated by Reference. The following sections of the April 1999 version of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act are incorporated by reference into these rules: (3-30-01)

- a. Basic Hospital Expense Coverage. (3-30-01)
- b. Basic Medical-Surgical Expense Coverage. (3-30-01)
- c. Basic Hospital/Medical-surgical Expense Coverage. (3-30-01)
- d. Hospital Confinement Indemnity Coverage. (3-30-01)
- e. Individual Major Medical Expense Coverage. (3-30-01)
- f. Disability Income Protection Coverage. (3-30-01)
- g. Accident Only Coverage. (3-30-01)
- h. Specified Disease or Specified Accident Coverage. (3-30-01)
- i. Limited Benefit Health Coverage. (3-30-01)
- j. Dental Plans. (3-30-01)
- k. Vision Plans. (3-30-01)
- l. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (direct sales). (3-30-01)
- m. Notice to Applicant Regarding Placement of Accident and Sickness Insurance (other than direct sales). (3-30-01)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-28-18)

02. Mailing Address. The department’s mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (3-28-18)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-28-18)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (3-28-18)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code, as well as applicable exemptions. (3-28-18)

007. -- 009. (RESERVED)

010. DEFINITIONS.

Except as provided in this rule, an individual accident and sickness insurance policy or group supplemental health insurance policy delivered or issued for delivery to any person in this state and to which this rule applies shall contain definitions respecting the matters set forth below that comply with the requirements of Section 004. (3-30-01)

01. Accident. “Accident,” “accidental injury,” and “accidental” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization. (3-30-01)

a. The definition shall not be more restrictive than the following: “injury” or “injuries” means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. (3-30-01)

b. The definition may provide that injuries shall not include injuries for which: (3-30-01)

i. Benefits are provided under workers’ compensation, employers’ liability, or similar law; or (3-30-01)

ii. Under a motor vehicle no-fault plan, unless prohibited by law; or (3-30-01)

iii. Injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. (3-30-01)

02. Convalescent Nursing Home. “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” shall be defined in relation to its status, facility and available services. (3-30-01)

a. A definition of the home or facility shall not be more restrictive than one requiring that it: (3-30-01)

i. Be operated pursuant to law; (3-30-01)

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; (3-30-01)

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; (3-30-01)

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and (3-30-01)

v. Maintain a daily medical record of each patient. (3-30-01)

b. The definition of the home or facility may provide that the term shall not be inclusive of: (3-30-01)

i. A home, facility or part of a home or facility used primarily for rest; (3-30-01)

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or (3-30-01)

iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care. (3-30-01)

03. 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 Healthcare Organizations. (3-30-01)

a. The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital: (3-30-01)

i. Be an institution licensed to operate as a hospital pursuant to law; (3-30-01)

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 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 (3-30-01)

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. (3-30-01)

b. The definition of the term “hospital” may state that the term shall not be inclusive of the following, unless the facility otherwise meets the qualifications set forth at Subsection 004.03.a. of this rule: (3-30-01)

i. Convalescent homes or, convalescent, rest, or nursing facilities; (3-30-01)

ii. Facilities affording primarily custodial, educational, or rehabilitative care; (3-30-01)

iii. Facilities for the aged, drug addicts, or alcoholics; or (3-30-01)

iv. A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. (3-30-01)

04. Medicare. Means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. (3-30-01)

05. Mental or Nervous Disorders. Shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. (3-30-01)

06. Nurse. May be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Idaho. (3-30-01)

07. One Period of Confinement. Means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days. (3-30-01)

08. 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. (3-30-01)

09. Physician. May be defined by including words such as “qualified physician” or “licensed physician.” The use of these 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 the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws. (3-30-01)

- 10. Preexisting Condition.** Shall not be defined more restrictively than the following: (3-30-01)
- a.** A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual’s coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than: (3-30-01)
 - i.** A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (3-30-01)
 - ii.** A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (3-30-01)
 - iii.** A pregnancy existing on the effective date of coverage. (3-30-01)
 - b.** A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. (3-30-01)
 - c.** An individual carrier shall not modify a health benefit plan with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. (3-30-01)
- 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 that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or other term of similar import that in the opinion of the Director adequately and fairly describes the benefit. (3-30-01)
- 12. Sickness or Illness.** Shall not be defined to be more restrictive than the following: “Sickness (or Illness) means sickness 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 sickness or disease for which benefits are provided under a worker’s compensation, occupational disease, employers’ liability or similar law.” (3-30-01)
- 13. Total Disability.** Shall be defined in accordance with the following limitations: (3-30-01)
- a.** A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. (3-30-01)
 - 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: (3-30-01)
 - i.** Perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of his occupation”; or (3-30-01)
 - ii.** Engage in a training or rehabilitation program. (3-30-01)
 - c.** An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her 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. (3-30-01)

011. PROHIBITED POLICY PROVISIONS.

01. Probationary or Waiting Period. Except as provided in Subsection 004.10 pertaining to the definition of a preexisting condition, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. Accident policies shall not contain probationary or waiting periods. (3-30-01)

02. Additional Coverage as Dividend. A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months. (3-30-01)

a. The initial renewal subsequent to the issuance of a 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 the renewal is optional. (3-30-01)

03. Return of Premium or Cash Value Benefit. A disability income policy, accident only policy, limited benefit policy, specified disease policy or hospital confinement indemnity policy may contain a “return of premium” or “cash value benefit” so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to this rule shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds. (3-28-18)

04. Federally Operated Hospital. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government. (3-30-01)

05. Exclusions. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows: (3-30-01)

- a.** Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child; (3-30-01)
- b.** Mental or emotional disorders, alcoholism and drug addiction; (3-30-01)
- c.** Pregnancy, except for complications of pregnancy; (3-30-01)
- d.** Illness, treatment or medical condition arising out of: (3-30-01)
 - 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 to it; (3-30-01)
 - ii.** Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; (3-30-01)
 - iii.** Aviation; (3-30-01)
 - iv.** With respect to short-term nonrenewable policies, interscholastic sports; and (3-30-01)
 - v.** With respect to disability income protection policies, incarceration. (3-30-01)
- e.** Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the 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; (3-30-01)
- f.** Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (3-30-01)

g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; (3-30-01)

h. Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law; 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; (3-30-01)

i. Dental care or treatment; (3-30-01)

j. Eye glasses and examination for the prescription, or fitting of them; (4-11-19)

k. Rest cures, custodial care, transportation, and routine physical examinations; (4-11-19)

l. Territorial limitations; and (4-11-19)

m. Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device. (4-11-19)

06. Authority of Director to Disapprove. Policy provisions precluded in Section 011 shall not be construed as a limitation on the authority of the Director to disapprove other policy provisions in accordance with Chapters 21, 22 and 42 of Title 41 of the Idaho Code, or that in the opinion of the Director are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy. (3-30-01)

Accident and Sickness Minimum Standards for Benefits
(Sections 012 through 029)

012. ACCIDENT AND SICKNESS MINIMUM STANDARDS FOR BENEFITS.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. An individual accident and sickness insurance policy or group supplemental health insurance policy shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the Director finds that the policies or contracts are allowable as limited benefit health insurance and the outline of coverage complies with the model outline of coverage established by the National Association of Insurance Commissioners ("NAIC") and accessible by the Internet at www.doi.state.id.us, under the "Consumer Assistance" link, for each category of coverage noted in Sections 013 through 029. Section 012 shall not preclude the issuance of any policy or contract combining two (2) or more categories set forth in Section 41-4204(1) and 41-4204(2), Idaho Code. Limitations on coinsurance percentages set forth in this rule do not apply to out-of-network benefits offered as part of a managed care plan. (3-30-01)

013. GENERAL RULES.

01. Termination of Coverage of Spouse Limitations. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual accident and sickness 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. In addition, 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. (3-30-01)

a. 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 Section 101 of this rule. (3-30-01)

b. The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual accident and sickness policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until 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. (3-30-01)

c. An individual accident and sickness or individual accident-only policy that 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 sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed. (3-30-01)

d. Except as provided in Section 013 of this rule, (the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare and to the extent not in conflict with Health Insurance Portability and Accountability Act, HIPAA), 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 where the insurer is able to show good cause for changing the policy provisions and obtains prior written approval from the Director. The insurer may make changes in premium rates by classes. (3-30-01)

02. Age and Durational Requirements. In an individual accident and sickness policy covering both husband and wife, the age of the younger spouse shall 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 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 the policy.(3-30-01)

03. Accidental Death and Dismemberment Coverage. When accidental death and dismemberment coverage is part of the individual accident and sickness insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured. (3-30-01)

04. Military Service Limitations. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis. (3-30-01)

05. Pregnancy Benefit Extension. 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. (3-30-01)

06. Convalescent or Extended Care Benefits. Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital. (3-30-01)

07. Coverage of Dependents. A policy’s coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. Provisions relating to coverage of dependents with mental or physical handicaps shall meet the requirements of Sections 41-2139 and 41-2203, Idaho Code. (3-30-01)

08. Expenses of Live Donor. A 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 or certificate, after benefits for the recipient's own expenses have been paid. (3-30-01)

09. Recurrent Disabilities. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months. (3-30-01)

10. Accidental Death and Dismemberment. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) 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 (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force. (3-30-01)

11. Specific Dismemberment Benefits. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits. (3-30-01)

12. Accident Only Policy. An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy. (3-30-01)

13. Continuous Loss. Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits. (3-30-01)

14. Fractures or Dislocations. A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations. (3-30-01)

014. BASIC HOSPITAL EXPENSE COVERAGE.

A policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a 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: (3-30-01)

01. Daily Hospital Room and Board. Daily hospital room and board in an amount not less than the lesser of: (3-30-01)

a. Eighty percent (80%) of the charges for semiprivate room accommodations; or (3-30-01)

b. One hundred dollars (\$100) per day. (3-30-01)

02. Miscellaneous Services. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either eighty percent (80%) of the charges incurred up to at least three thousand dollars (\$3,000) or ten (10) times the daily hospital room and board benefits; and (3-30-01)

03. Hospital Outpatient Services. Hospital outpatient services consisting of: (3-30-01)

a. Hospital services on the day surgery is performed; (3-30-01)

b. Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than one hundred fifty dollars (\$150); and (3-30-01)

c. X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than one hundred dollars (\$100) if rendered to an in-patient of the hospital. (3-30-01)

04. Combined Deductible. Benefits provided under Subsections 014.01 and 014.02 of this rule may be provided subject to a combined deductible amount not in excess of one hundred dollars (\$100). (3-30-01)

015. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE.

A policy of accident and sickness insurance that 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: (3-30-01)

01. Surgical Services. Surgical services shall be: (3-30-01)

a. In amounts not less than those provided on a fee schedule based on the relative values contained in the most recent Medicare Resource Based Relative Value Scale, or as defined to the Director, utilizing Current Procedure Terminology (CPT) coding or other acceptable relative value schedule, up to a maximum of at least one thousand dollars (\$1000) for one procedure; or (3-30-01)

b. Not less than eighty percent (80%) of the reasonable charges. (3-30-01)

02. Anesthesia Services. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services in an amount not less than: (3-30-01)

a. Eighty percent (80%) of the reasonable charges; or (3-30-01)

b. Fifteen percent (15%) of the surgical service benefit. (3-30-01)

03. In-Hospital Medical Services. 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: (3-30-01)

a. Eighty percent (80%) of the reasonable charges; or (3-30-01)

b. Fifty dollars (\$50) per day for not less than twenty-one (21) days during one period of confinement. (3-30-01)

016. BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE.
A combined coverage and must meet the requirements of both Sections 014 and 015. (3-30-01)

017. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.

01. Hospital Confinement Indemnity Coverage. A policy of accident and sickness insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than forty dollars (\$40) per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy. (3-30-01)

02. Preexisting Condition Limitation. Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded. (3-30-01)

03. No Coordination of Benefits. Benefits shall be paid regardless of other coverage. (3-30-01)

018. INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE.

01. Major Medical Expense Coverage. An accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than five hundred thousand dollars (\$500,000); coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum combined with any deductibles shall not exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person for at least: (3-30-01)

a. Daily hospital room and board expenses subject only to limitations based on average daily cost of

the semiprivate room rate in the area where the insured resides; (3-30-01)

b. Miscellaneous hospital services; (3-30-01)

c. Surgical services; (3-30-01)

d. Anesthesia services; (3-30-01)

e. In-hospital medical services; and (3-30-01)

f. Out-of-hospital care, 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, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician. (3-30-01)

02. Additional Benefits. Individual major medical expense coverage must also provide not fewer than three (3) of the following additional benefits: (3-30-01)

a. In-hospital private duty registered nurse services; (3-30-01)

b. Convalescent nursing home care; (3-30-01)

c. Diagnosis and treatment by a radiologist or physiotherapist; (3-30-01)

d. Rental of special medical equipment, as defined by the insurer in the policy; (3-30-01)

e. Artificial limbs or eyes, casts, splints, trusses or braces; (3-30-01)

f. Treatment for functional nervous disorders, and mental and emotional disorders; or (3-30-01)

g. Out-of-hospital prescription drugs and medications. (3-30-01)

03. Deductible Application. If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage. (3-30-01)

04. Benefit Requirements. The minimum benefits required by Subsection 018.01 may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection 018.02 and other such special or internal limitations as are authorized or approved by the Director. Except as authorized by Subsection 018.04 through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to prior written approval by the Director or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum. (3-30-01)

019. DISABILITY INCOME PROTECTION COVERAGE.

A policy that 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 of them that: (3-30-01)

01. Periodic Payments. Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62); (3-30-01)

02. Elimination Period. Contains an elimination period no greater than: (3-30-01)

a. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less; (3-30-01)

b. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years; or (3-30-01)

c. Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury; (3-30-01)

03. Payable Time Period During Disability. Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. (3-30-01)

04. One Elimination Period. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required. (3-30-01)

020. ACCIDENT ONLY COVERAGE.

A policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least one thousand dollars (\$1000) and a single dismemberment amount shall be at least five hundred dollars (\$500). (3-30-01)

021. SPECIFIED DISEASE COVERAGE.

01. Specified Disease Coverage. Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. A specified disease policy must meet the following rules and one (1) of the following sets of minimum standards for benefits, as defined in Section 021 for cancer only policies, or other specified disease coverage. (3-30-01)

a. Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Sections 024, 025, or 027 of this rule. (3-30-01)

b. Insurance covering specified diseases other than cancer must meet the standards of Sections 023 or 027 of this rule. (3-30-01)

02. General Rules. Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other requirements imposed by this rule. In cases of conflict Subsections 021.02.a. through 021.02.l., shall govern: (3-30-01)

a. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under Section 021 of this rule. (3-30-01)

b. Any policy issued pursuant to Section 021 of this rule that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. (3-30-01)

c. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease. (3-30-01)

d. Individual accident and sickness policies containing specified disease coverage shall be guaranteed renewable. (3-30-01)

e. No policy issued pursuant to Section 021 shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person. (3-30-01)

f. An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not also covered by any Title XIX program (Medicaid, or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature. (3-30-01)

g. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. (3-30-01)

h. Benefits for specified disease coverage shall be paid regardless of other coverage. (3-30-01)

i. After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis. (3-30-01)

j. Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges." (3-30-01)

k. Preexisting condition shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person." (3-30-01)

l. Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded. (3-30-01)

022. HOSPICE CARE.

01. Hospice Care. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: (3-30-01)

a. For terminally ill patients whose life expectancy is less than six (6) months; (3-30-01)

b. Provided on an inpatient or outpatient basis; and (3-30-01)

c. Directed by a physician. (3-30-01)

02. Optional Benefit. Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: (3-30-01)

a. Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; (3-30-01)

b. A fixed-sum payment of at least fifty dollars (\$50) per day; and (3-30-01)

c. A lifetime maximum benefit limit of at least ten thousand dollars (\$10,000). (3-30-01)

03. Non-Terminally Ill Patients. Hospice care does not cover non-terminally ill patients who may be confined in a: (3-30-01)

a. Convalescent home; (3-30-01)

b. Rest or nursing facility; (3-30-01)

c. Skilled nursing facility; (3-30-01)

- d. Rehabilitation unit; or (3-30-01)
- e. Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers. (3-30-01)

023. NON-CANCER COVERAGES.

The following minimum benefits standards apply to non-cancer coverages: (3-30-01)

01. Minimum Benefit Standards for Non-Cancer Coverages. Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars (\$250) and an overall aggregate benefit limit of not less than ten thousand dollars (\$10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses: (3-30-01)

- a. Hospital room and board and any other hospital furnished medical services or supplies; (3-30-01)
- b. Treatment by a legally qualified physician or surgeon; (3-30-01)
- c. Private duty services of a registered nurse (R.N.); (3-30-01)
- d. X-ray, radium and other therapy procedures used in diagnosis and treatment; (3-30-01)
- e. Professional ambulance for local service to or from a local hospital; (3-30-01)
- f. Blood transfusions, including expense incurred for blood donors; (3-30-01)
- g. Drugs and medicines prescribed by a physician; (3-30-01)
- h. The rental of an iron lung or similar mechanical apparatus; (3-30-01)
- i. Braces, crutches, and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; (3-30-01)
- j. 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 (3-30-01)
- k. May include coverage of any other expenses necessarily incurred in the treatment of the disease. (3-30-01)

02. Benefit Limits for Specifically Named Disease. Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty five thousand dollars (\$25,000) payable at the rate of not less than fifty dollars (\$50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days. (3-30-01)

024. CANCER-ONLY OR COMBINATION POLICIES.

A policy that provides coverage for each insured person for cancer-only coverage or in combination with one (1) or more other specified diseases on an expense incurred basis for services, supplies, care, and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars (\$250), and an overall aggregate benefit limit of not less than ten thousand dollars (\$10,000) and a benefit period of not less than three (3) years shall provide at least the following minimum provisions: (3-30-01)

01. Qualified Physician or Surgeon. Treatment by, or under the direction of, a legally qualified physician or surgeon; (3-30-01)

02. X-Ray and Therapy Procedures. X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment; (3-30-01)

- 03. Hospital.** Hospital room and board and any other hospital furnished medical services or supplies; (3-30-01)
- 04. Blood Transfusions.** Blood transfusions and their administration, including expense incurred for blood donors; (3-30-01)
- 05. Prescription Medicines.** Drugs and medicines prescribed by a physician; (3-30-01)
- 06. Ambulance Services.** Professional ambulance for local service to or from a local hospital; (3-30-01)
- 07. Private Duty Nurse.** Private duty services of a registered nurse provided in a hospital; (3-30-01)
- 08. Medical Equipment.** Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease; (3-30-01)
- 09. Emergency Transportation to Referral Treatment Facility.** 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 (3-30-01)
- 10. Home Health Care and Treatment.** Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required. A "home health care agency" is an agency approved under Medicare, or is licensed to provide home health care under applicable state law, or meets all of the following requirements: (3-30-01)
- a.** It is primarily engaged in providing home health care services; (3-30-01)
 - b.** Its policies are established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse); (3-30-01)
 - c.** A physician or a registered nurse provides supervision of home health care services; (3-30-01)
 - d.** It maintains clinical records on all patients; and (3-30-01)
 - e.** It has a full time administrator. (3-30-01)
- 11. Home Health Care.** Home health care includes, but is not limited to: (3-30-01)
- a.** Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; (3-30-01)
 - b.** Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech, or hearing occupational therapists; (3-30-01)
 - c.** Physical, occupational, or speech and hearing therapy; and (3-30-01)
 - d.** Medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital. (3-30-01)
- 12. Therapy.** Therapy includes physical, speech, hearing, and occupational therapy; (3-30-01)
- 13. Special Equipment.** Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances; (3-30-01)

14. **Prosthetic Devices.** Prosthetic devices including wigs and artificial breasts; (3-30-01)
15. **Non-Custodial Services.** Nursing home care for non-custodial services; and (3-30-01)
16. **Reconstructive Surgery.** Reconstructive surgery when deemed necessary by the attending physician. (3-30-01)

025. PER DIEM CANCER COVERAGES.

The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: (3-30-01)

01. Minimum Benefit Payment Based on Hospital Confinement. A fixed-sum payment of at least one hundred dollars (\$100) for each day of hospital confinement for at least three hundred sixty-five (365) days; (3-30-01)

02. Minimum Benefit Payment Based on Out-Patient Services. A fixed-sum payment equal to one-half (1/2) the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment; and (3-30-01)

03. Minimum Benefit Payment Based on Administration of Plasma or Blood Donor. A fixed-sum payment of at least fifty dollars (\$50) per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least three hundred sixty-five (365) days of treatment. (3-30-01)

026. NURSING HOME BENEFITS.

Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following: (3-30-01)

01. Minimum Benefit Standards Based on Nursing Home Confinement. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days. (3-30-01)

02. Minimum Benefit Standards Based on Home Health Care. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of home health care for at least one hundred (100) days. (3-30-01)

03. Benefit Payments. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease. (3-30-01)

04. Restrictions or Limitations. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in Subsections 026.01. and 026.02. of this rule, whether by definition or otherwise, shall be no more restrictive than those under Medicare. (3-30-01)

027. LUMP SUM INDEMNITY COVERAGE.

The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease: (3-30-01)

01. Indemnity Benefit, Specific Disease. These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of one thousand dollars (\$1,000). (3-30-01)

02. Equal Coverage. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits. (3-30-01)

028. SPECIFIED ACCIDENT COVERAGE.

A policy that 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 one thousand dollars (\$1,000) for double dismemberment and five hundred dollars (\$500) for single dismemberment. (3-30-01)

029. LIMITED BENEFIT HEALTH COVERAGE.

01. Limited Benefit Plan. A policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Sections 014, 015 through 018, 020, and 028 of this rule. Limited Benefit Health Coverage policies or contracts may be delivered or issued for delivery in this state only if an outline of coverage meeting the requirements of this rule for “Limited Benefit Health Coverage” is completed and delivered as required by Subsection 101.01.n. of this rule and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Subsection 101.01.a. A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 021 of this rule, and shall not be offered for sale as a “limited coverage.” (3-30-01)

02. Limited Benefit Plan Exceptions. Subsection 029.02 does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in Chapter 46, Title 41, Idaho Code, “Long-Term Care Insurance” and Chapter 44, Title 41, Idaho Code, “Medicare Supplement Insurance Minimum Standards.” (3-30-01)

030. -- 100. (RESERVED)

101. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules. (3-30-01)

a. All applications for coverages specified in Sections 014 through 018, 020, 028, and 029 of this rule shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows: “The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully.” (3-30-01)

b. All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows: “The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate) carefully.” (3-30-01)

c. All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows: “The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully.” (3-30-01)

d. Each policy of individual accident and sickness insurance and group supplemental health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear 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. (3-30-01)

e. 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 that 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 that increases

benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium. (3-30-01)

f. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate. (3-30-01)

g. A policy or certificate that 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 the terms and an explanation of the terms in its accompanying outline of coverage. (3-30-01)

h. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Preexisting Condition Limitations.” (3-30-01)

i. All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: “Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully.” (3-30-01)

j. Accident-only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the Notice to Buyer required by Subsection 101.01.i.: “This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” (3-30-01)

k. All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. (3-30-01)

l. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage. (3-30-01)

m. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: (3-30-01)

i. The caption of the provision shall be “Conversion Privilege” or words of similar import. (3-30-01)

ii. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. (3-30-01)

iii. 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. (3-30-01)

n. Outlines of coverage delivered in connection with policies defined as “Hospital Confinement Indemnity Coverage” in Section 017, “Specified Disease Coverage” in Subsection 012.09, or “Limited Benefit Health Coverage” in Section 029 of this rule to persons eligible for Medicare by reason of age shall contain the information for hospital confinement indemnity providing limited benefits (supplemental benefits) and Accident-Only Coverage as set forth in the model outlines of coverage found on the Department of Insurance Internet web-site at www.doi.state.id.us, “Consumer Assistance” link. In addition, the following language shall be printed on or attached to the first page of the outline of coverage: “THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the ‘Guide to Health Insurance for People With Medicare’ available from the

company.” (3-30-01)

i. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.04.10, Section 019, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.” (3-30-01)

o. All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate a prominent statement as follows: “Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage.” (3-30-01)

p. All hospital confinement indemnity policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a hospital confinement indemnity (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” (3-30-01)

q. All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a limited benefit health (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” (3-30-01)

r. All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic hospital expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” (3-30-01)

s. All basic medical-surgical expense policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” (3-30-01)

t. All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic hospital/medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” (3-30-01)

u. All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This (policy) (certificate) provides dental benefits only.” (3-30-01)

v. All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This (policy) (certificate) provides vision benefits only.” (3-30-01)

02. Outline of Coverage Requirements. Outlines of coverage required under this rule will conform to

the model outlines of coverage as set forth at the Idaho Department of Insurance web-site, www.doi.state.id.us, under the consumer assistance link. (3-30-01)

a. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans as required by Section 41-4205, Idaho Code, that conforms to Subsection 013.03 of this rule. (3-30-01)

b. If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) 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) (enrollment), and the coverage originally applied for has not been issued.” (3-30-01)

c. The appropriate outline of coverage for policies or contracts providing hospital coverage that only meet the standards of Section 014 shall be that statement contained in the model outline of coverage for Basic Hospital Expense Coverage, as set forth at the Department of Insurance Internet website, www.doi.state.id.us. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 014 and 015, shall be the statement contained in the model outline-of coverage for Basic Hospital/Medical-Surgical Expense Coverage, as set forth at the Department web-site. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 014 and 017, or Sections 016 and 017, or Sections 014, 015, and 017 shall be the statement contained in the model outline of coverage for Individual Major Medical Expense Coverage as set forth at the Department web-site. (3-30-01)

d. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the Director for prior written approval. (3-30-01)

102. -- 200. (RESERVED)

201. REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE.

01. Application Form. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used. (3-30-01)

02. Required Notice. Upon determining that a sale will involve replacement, an insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the “Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance,” taking into consideration the requirement for direct response or other than direct response. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Section 201. (3-30-01)

202. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 09**

18.04.09 – COMPLICATIONS OF PREGNANCY

000. LEGAL AUTHORITY.

Sections 41-2140, 41-2210, 41-3438, 41-3932, 41-4023, and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

This rule is titled IDAPA 18.04.09, “Complications of Pregnancy,” and define the intent of the provisions pertaining to involuntary complications of pregnancy under Chapters 21, 22, 34, 39, and 40, Idaho Code. (7-1-93)

002. -- 010. (RESERVED)

011. COVERAGE.

01. Applicability. The provisions of this rule shall apply to all contracts regulated by Chapters 21, 22, 34, 39, and 40 which provide maternity benefits for a person covered continuously from conception. When the contract does not provide maternity benefits, the provisions of this rule do not apply. (7-1-93)

02. Involuntary Complications of Pregnancy. Involuntary complications of pregnancy, as that term is used in Sections 41-2140(2), 41-2210(2), 41-3438, 41-3932, and 41-4023, Idaho Code, includes but is not limited to: (7-1-93)

a. Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (7-1-93)

b. Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia. (7-1-93)

012. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 10**

**18.04.10 – RULE TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE
MINIMUM STANDARDS MODEL ACT**

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapters 2 and 44, Title 41, Idaho Code. (4-5-00)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.10, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.” (3-29-10)

02. Scope. (4-5-00)

a. Except as otherwise specifically provided in Sections 020, 046, 051, 066, and 077, this rule applies to: (4-11-19)

i. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and (4-5-00)

ii. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state. (4-5-00)

b. This rule does not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organization. (4-5-00)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and at each regional or district office of this agency. (4-5-00)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-29-10)

004. INCORPORATION BY REFERENCE.

This rule incorporates by reference Appendixes A (Refund Calculation and Calculation of Benchmark forms Model Regulation 651 pages 651-94 to 651-97), B (Form for Reporting Medicare Supplement Policies, page 651-98), and C (Disclosure Statements pages 651-99 to 651-108), and all other outlines of coverage and specific plan designs of the National Association of Insurance Commissioners (NAIC) Model Regulation 651 (pages 651-42 to 651-85) implementing the Medicare supplement insurance minimum standards (2018). The Model Regulation is available from the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662 and from the Idaho Department of Insurance. (4-11-19)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-29-10)

02. Mailing Address. The department’s mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (3-29-10)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (3-29-10)

04. Web Site Address. The department’s website is <https://doi.idaho.gov>. (3-29-10)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-29-10)

007. -- 009. (RESERVED)

010. DEFINITIONS.

For the purposes of this rule, the following terms will be used as defined below: (3-29-10)

01. Applicant. (4-5-00)

a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and (4-5-00)

b. In the case of a group Medicare supplement policy, the proposed certificate holder. (4-5-00)

02. Bankruptcy. A Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state. (4-11-06)

03. Certificate. Any certificate delivered or issued for delivery in this state under a group Medicare supplement policy. (4-5-00)

04. Certificate Form. The form on which the certificate is delivered or issued for delivery by the issuer. (4-5-00)

05. Continuous Period of Creditable Coverage. The period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days. (4-5-00)

06. Creditable Coverage. (4-5-00)

a. With respect to an individual, coverage of the individual provided under any of the following: (4-5-00)

i. A group health plan; (4-5-00)

ii. Health insurance coverage; (4-5-00)

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare); (4-5-00)

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (4-5-00)

v. Chapter 55 of Title 10 United States Code (CHAMPUS); (4-5-00)

vi. A medical care program of the Indian Health Service or of a tribal organization; (4-5-00)

vii. A state health benefits risk pool; (4-5-00)

viii. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); (4-5-00)

- ix. A public health plan as defined in federal regulation; and (4-5-00)
- x. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). (4-5-00)
- b.** Creditable coverage shall not include one (1) or more, or any combination of, the following: (4-5-00)
 - i. Coverage only for accident or disability income insurance, or any combination thereof; (4-5-00)
 - ii. Coverage issued as a supplement to liability insurance; (4-5-00)
 - iii. Liability insurance, including general liability insurance and automobile liability insurance; (4-5-00)
 - iv. Workers' compensation or similar insurance; (4-5-00)
 - v. Automobile medical payment insurance; (4-5-00)
 - vi. Credit-only insurance; (4-5-00)
 - vii. Coverage for on-site medical clinics; and (4-5-00)
 - viii. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. (3-29-10)
- c.** Creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: (4-5-00)
 - i. Limited scope dental or vision benefits; (4-5-00)
 - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and (4-5-00)
 - iii. Such other similar, limited benefits as are specified in federal regulations. (4-5-00)
- d.** Creditable coverage shall not include the following benefits if offered as independent, non-coordinated benefits: (4-5-00)
 - i. Coverage only for a specified disease or illness; and (4-5-00)
 - ii. Hospital indemnity or other fixed indemnity insurance. (4-5-00)
- e.** Creditable coverage shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: (4-5-00)
 - i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; (3-29-10)
 - ii. Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and (4-5-00)
 - iii. Similar supplemental coverage provided to coverage under a group health plan. (4-5-00)
- f.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addressed separate, noncoordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at

Section 2791(c)(3). HIPAA also references excepted benefits at PHS Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, credible coverage has been addressed in an interim final rule (62 Fed. Reg. At 16960-16962 (April 8, 1997)) issued by the Secretary of Health and Human Services, pursuant to HIPAA, and may be addressed in subsequent regulations. (4-1-06)

07. Employee Welfare Benefit Plan. A plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act). (4-5-00)

08. Insolvency. When an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile. (4-5-00)

09. Issuer. Includes insurance companies, fraternal benefit societies, managed care organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates. (4-5-00)

10. Medicare. The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. (4-5-00)

11. Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes: (4-11-06)

a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (4-5-00)

b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and (4-11-06)

c. Medicare Advantage private fee-for-service plans. (4-11-06)

12. Medicare Supplement Policy. A group or individual policy of accident and sickness insurance or an enrollee contract under a managed care organization, other than a policy issued pursuant to a contract under Section 1876 of the federal 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), 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. "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C. Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act; provided, however, that under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) must comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act. (3-29-10)

13. Pre-Standardized Medicare Supplement Benefit Plan. A group or individual policy of Medicare supplement insurance issued prior to July 1, 1992. (3-29-10)

14. 1990 Standardized Medicare Supplement Benefit Plan. A group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured. (3-29-10)

15. 2010 Standardized Medicare Supplement Benefit Plan. A group or individual policy of Medicare supplement insurance with an effective date for coverage issued on or after June 1, 2010. (3-29-10)

16. Policy Form. The form on which the policy is delivered or issued for delivery by the issuer. (4-5-00)

17. **Secretary.** The Secretary of the United States Department of Health and Human Services. (4-5-00)

011. POLICY DEFINITIONS AND TERMS.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section. (4-5-00)

01. Accident, Accidental Injury, or Accidental Means. To employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization. (3-29-10)

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.” (4-5-00)

b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability or similar law, or motor vehicle no-fault plan, unless prohibited by law. (4-5-00)

02. Benefit Period or Medicare Benefit Period. Shall not be defined more restrictively than as defined in the Medicare program. (4-5-00)

03. Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility. Shall not be defined more restrictively than as defined in the Medicare program. (4-5-00)

04. Health Care Expenses. For purposes of Section 051, expenses of managed care organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. (4-11-19)

05. 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, but not more restrictively than as defined in the Medicare program. (4-5-00)

06. Medicare. Shall be defined in the policy and certificate. 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 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. (3-29-10)

07. Medicare Eligible Expenses. Expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare. (4-11-06)

08. Physician. Shall not be defined more restrictively than as defined in the Medicare program. (4-5-00)

09. Sickness. Shall not be defined to be more restrictive than the following: “Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability, or similar law. (4-5-00)

012. POLICY PROVISIONS.

01. Medicare Supplement Policy. Except for permitted preexisting condition clauses as described in Paragraphs 020.01.a., 021.01.a. and 022.01.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. (3-29-10)

02. Waivers. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. (4-5-00)

03. Duplicate Benefits. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare. (4-5-00)

04. Outpatient Prescription Drugs. (4-11-06)

a. Subject to Paragraphs 020.01.d., 020.01.e., 020.01.j., and 021.01.d., and 021.01.e. of this rule, a Medicare Supplement Policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder. (3-29-10)

b. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005. (4-11-06)

c. 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: (4-11-06)

i. 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 (4-11-06)

ii. 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. (4-11-06)

013. -- 019. (RESERVED)

020. MINIMUM BENEFIT STANDARDS FOR PRE-STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992.

No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards. (3-29-10)

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule. (3-29-10)

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (4-5-00)

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (4-5-00)

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes. (3-29-10)

d. A "non-cancelable," "guaranteed renewable," or "non-cancelable and guaranteed renewable" Medicare supplement policy shall not: (4-5-00)

i. 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; or (4-5-00)

- ii. Be canceled or non-renewed by the issuer solely on the grounds of deterioration of health. (4-5-00)
 - e. Except as authorized by the director of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. (4-5-00)
 - f. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 020.01.h., the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices: (3-29-10)
 - i. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and (3-29-10)
 - ii. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 021.02. (3-29-10)
 - g. If membership in a group is terminated, the issuer shall: (4-5-00)
 - i. Offer the certificateholder the conversion opportunities described in Paragraph 020.01.f.; or (3-29-10)
 - ii. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy. (3-29-10)
 - h. 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 shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced. (4-5-00)
 - i. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss. (4-11-06)
 - j. If a Medicare supplement policy 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 shall be deemed to satisfy the guaranteed renewal requirements of Subsection 020.01. (3-29-10)
- 02. Minimum Benefit Standards.** (4-5-00)
- 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; (4-5-00)
 - b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount; (4-5-00)
 - c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days; (4-5-00)
 - d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) 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 (365) days; (4-5-00)
 - e. Coverage under Medicare Part A for the reasonable cost of the first three (3) 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; (4-5-00)

f. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payments system, the copayment 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; (5-3-03)

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) 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. (4-5-00)

021. BENEFIT STANDARDS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992 AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992, and with an effective date for coverage prior to June 1, 2010. 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. (3-29-10)

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule. (3-29-10)

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (4-5-00)

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (4-5-00)

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes. (3-29-10)

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. (4-5-00)

e. Each Medicare supplement policy shall be guaranteed renewable. (4-5-00)

i. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual. (4-5-00)

ii. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation. (4-5-00)

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 021.01.e.v., the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder): (3-29-10)

(1) Provides for continuation of the benefits contained in the group policy; or (4-5-00)

(2) Provides for benefits that otherwise meet the requirements of Subsection 021.01 through 021.01.h.iv. (3-29-10)

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall (a) offer the certificateholder the conversion opportunity described in Subparagraph 021.01.e.iii.; or, (b) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy. (3-29-10)

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 shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced. (4-5-00)

vi. If a Medicare supplement policy 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 shall be deemed to satisfy the guaranteed renewal requirements of Paragraph 021.01.e. (3-29-10)

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss. (4-11-06)

g. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance. (3-29-10)

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically re-instituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. (3-29-10)

ii. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall 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 shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. (5-3-03)

iii. Reinstitution of coverages as defined in Subparagraphs 021.01.g.i. and 021.01.g.ii.: (3-29-10)

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions; (4-5-00)

(2) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and (4-11-06)

(3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended. (3-29-10)

h. If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one (1) or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 023 of this rule) to a 2010 Standardized plan (as described in Section 024 of this rule), the offer and subsequent exchange shall comply with the following requirements: (3-29-10)

i. An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchange policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director. (3-29-10)

ii. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage. (3-29-10)

iii. An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy. (3-29-10)

iv. The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law. (3-29-10)

02. Standards for Basic (Core) Benefits Common to Benefit Plans A - J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each perspective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. (4-11-06)

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; (4-5-00)

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; (4-5-00)

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of 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 (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balances. (4-11-06)

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; (4-5-00)

e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services 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. In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the copayment amount established by federal requirements, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced copayment amount. (4-11-06)

03. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 023 of this rule. (3-29-10)

a. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period. (4-5-00)

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 post-hospital skilled nursing facility care eligible under Medicare Part A. (4-5-00)

c. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (4-5-00)

d. Eighty percent (80%) of the Medicare Part B excess charges: Coverage for eighty percent (80%) 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. (4-5-00)

e. One hundred percent (100%) 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. (4-5-00)

f. Basic outpatient prescription drug benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollars (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. (4-11-06)

g. Extended outpatient prescription drug benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollars (\$250) calendar year deductible, to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. (4-11-06)

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty-percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. (4-5-00)

04. Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare: (4-11-06)

a. An annual clinical preventive medical history and physical examination that may include tests and services from Paragraph 021.04.c., and patient education to address preventive health care measures. (3-29-10)

b. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician. (4-11-06)

c. Reimbursement shall be for the actual charges up to one hundred percent (100%) 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 (\$120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare. (4-11-06)

05. 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. For purposes of this benefit, the following definitions shall apply: (4-5-00)

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. (4-5-00)

b. Care provider. A duly qualified or licensed home health aide or 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. (4-5-00)

c. Home. 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 shall not be considered the insured's place of residence. (4-5-00)

d. At-home recovery visit. The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one (1) visit. (4-5-00)

06. Coverage Requirements and Limitations. (4-5-00)

a. At-home recovery services provided must be primarily services which assist in activities of daily living. (4-5-00)

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. (4-5-00)

c. Coverage is limited to: (4-5-00)

i. No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment; (4-5-00)

ii. The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit; (4-5-00)

iii. One thousand six hundred dollars (\$1,600) per calendar year; (4-5-00)

iv. Seven (7) visits in any one week; (4-5-00)

v. Care furnished on a visiting basis in the insured's home; (4-5-00)

vi. Services provided by a care provider as defined in this Section; (3-29-10)

vii. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; (4-5-00)

viii. At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit. (4-5-00)

d. Coverage is excluded for: (4-5-00)

i. Home care visits paid for by Medicare or other government programs; and (4-5-00)

ii. Care provided by family members, unpaid volunteers or providers who are not care providers. (4-5-00)

07. Standards for Plan K and L. (3-29-10)

a. Standardized Medicare supplement benefit plan "K" shall consist of the following: (3-29-10)

- i. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period; (4-11-06)
 - ii. Coverage of one hundred percent (100%) 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; (4-11-06)
 - iii. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days coverage of one hundred percent (100%) 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 (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (4-11-06)
 - iv. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph 021.07.a.x.; (3-29-10)
 - v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) 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 Subparagraph 021.07.a.x.; (3-29-10)
 - vi. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph 021.07.a.x.; (3-29-10)
 - vii. Coverage for fifty percent (50%) under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph 021.07.a.x.; (3-29-10)
 - viii. Except for coverage provided in Subparagraph 021.07.a.ix., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 021.07.a.x. (3-29-10)
 - ix. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (4-11-06)
 - x. Coverage of one hundred percent (100%) 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 (\$4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. (4-11-06)
- b. Standardized Medicare supplement benefit plan "L" shall consist of the following: (3-29-10)
 - i. The benefits described in Subparagraphs 021.07.a.i. through 021.07.a.iii., and 021.07.a.ix.; (3-29-10)
 - ii. The benefit described in Subparagraphs 021.07.a.v. through 021.07.a.viii. but substituting seventy-five percent (75%) for fifty percent (50%); and (3-29-10)
 - iii. The benefit described in Subparagraph 021.07.a.x. but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000). (3-29-10)

022. BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. 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. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of Section 021. (3-29-10)

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation. (3-29-10)

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage. (3-29-10)

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (3-29-10)

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes. (3-29-10)

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. (3-29-10)

e. Each Medicare supplement policy shall be guaranteed renewable. (3-29-10)

i. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual. (3-29-10)

ii. The issuer shall not cancel or nonrenew the policy for any reasons other than nonpayment of premium or material representation. (3-29-10)

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 022.01.e.v. of this rule, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder): (3-29-10)

(1) Provides for continuation of the benefits contained in the group policy; or (3-29-10)

(2) Provides for benefits that otherwise meet the requirements of this Subsection. (3-29-10)

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall: (3-29-10)

(1) Offer the certificateholder the conversion opportunity described in Subparagraph 022.01.e.iii. of this rule; or (3-29-10)

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy. (3-29-10)

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 shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion

for preexisting conditions that would have been covered under the group policy being replaced. (3-29-10)

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss. (3-29-10)

g. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance. (3-29-10)

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. (3-29-10)

ii. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall 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 shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within (90) days after the date of the loss and pays the premium attributed to the period, effective as of the date of termination of enrollment in the group health plan. (3-29-10)

iii. Reinstitution of coverages as described in Subparagraphs 022.01.g.i. and 022.01.g.ii.; (3-29-10)

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions; (3-29-10)

(2) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and (3-29-10)

(3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended. (3-29-10)

02. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it. (3-29-10)

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; (3-29-10)

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; (3-29-10)

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) 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 (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (3-29-10)

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; (3-29-10)

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; (3-29-10)

f. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses. (3-29-10)

03. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 024 of this rule. (3-29-10)

a. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (3-29-10)

b. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (3-29-10)

c. 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 post-hospital skilled nursing facility care eligible under Medicare Part A. (3-29-10)

d. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (3-29-10)

e. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. (3-29-10)

f. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. (3-29-10)

023. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1, 1992 AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010.

01. Policy Form or Certificate Form. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 021.02. (3-29-10)

02. Medicare Supplement Benefits. No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection 023.07 and in Section 031 of this rule. (4-11-19)

03. Benefit Plans. Benefit plans shall 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 Section 010 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 021.02, and 021.03 or 021.07, and list the benefits in the order shown in this Subsection. For purposes of Section 023, “structure, language, and format” means style, arrangement and overall content of a benefit. (3-29-10)

04. Other Designations. An issuer may use, in addition to the benefit plan designations required in Subsection 023.03, other designations to the extent permitted by law. (3-29-10)

05. Make-Up of Benefit Plans. (3-29-10)

a. Standardized Medicare supplement benefit plan “A” shall be limited to the basic (core) benefits common to all benefit plans, as defined in Subsection 021.02. (3-29-10)

b. Standardized Medicare supplement benefit plan “B” shall include only the following: The core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible as defined in Paragraph 021.03.a. (3-29-10)

c. Standardized Medicare supplement benefit plan “C” shall include only the following: The core benefit as defined in Subsection 021.02, 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 Paragraphs 021.03.a. through 021.03.c., and 021.03.h., respectively. (3-29-10)

d. Standardized Medicare supplement benefit plan “D” shall include only the following: The core benefit (as defined in Subsection 021.02), 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 Paragraphs 021.03.a., 021.03.b., 021.03.h., and Subsection 021.05, respectively. (3-29-10)

e. Standardized Medicare supplement benefit plan “E” shall include only the following: The core benefit as defined in Subsection 021.02, 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 Paragraphs 021.03.a., 021.03.b., 021.03.h., and Subsection 021.04, respectively. (3-29-10)

f. Standardized Medicare supplement benefit plan “F” shall include only the following: The core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 021.03.a. through 021.03.c., 021.03.e., and 021.03.h., respectively. (3-29-10)

g. Standardized Medicare supplement benefit high deductible plan “F” shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan “F” deductible. The covered expenses include the core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 021.03.a. through 021.03.c., 021.03.e., and 021.03.h., respectively. The annual high deductible plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “F” policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan “F” deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). (3-29-10)

h. Standardized Medicare supplement benefit plan “G” shall include only the following: The core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Paragraphs 021.03.a., 021.03.b., 021.03.d., 021.03.h., and Subsection 021.05, respectively. (3-29-10)

i. Standardized Medicare supplement benefit plan “H” shall consist of only the following: The core benefit as defined in Subsection 021.02, 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 Paragraphs 021.03.a., 021.03.b., 021.03.f., and 021.03.h., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005. (3-29-10)

j. Standardized Medicare supplement benefit plan “I” shall consist of only the following: The core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) 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 Paragraphs 021.03.a., 021.03.b., 021.03.e., 021.03.f., 021.03.h., and Subsection 021.05, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005. (3-29-10)

k. Standardized Medicare supplement benefit plan “J” shall consist of only the following: The core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) 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 Paragraphs 021.03.a. through 021.03.c., 021.03.e., 021.03.g., 021.03.h., and Subsections 021.04 and 021.05, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005. (3-29-10)

l. Standardized Medicare supplement benefit high deductible plan “J” shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan “J” deductible. The covered expenses include the core benefit as defined in Subsection 021.02, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Paragraphs 021.03.a. through 021.03.c., 021.03.e., 021.03.g., 021.03.h., and Subsections 021.04 and 021.05, respectively. The annual high deductible plan “J” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “J” policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005. (3-29-10)

06. Make-Up of Two Medicare Supplement Plans Mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). (3-29-10)

a. Standardized Medicare supplement benefit plan “K” shall consist of only those benefits described in Paragraph 021.07.a. (3-29-10)

b. Standardized Medicare supplement benefit plan “L” shall consist of only those benefits described in Paragraph 021.07.b. (3-29-10)

07. New or Innovative Benefits. An issuer may, with the prior approval of the director, 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 goals of simplification of Medicare supplement policies. After December 31, 2005 the innovative benefit shall not include an outpatient prescription drug benefit. (4-11-06)

024. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

01. General Standards. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010.

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 plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 023 of this rule. (4-11-19)

a. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02 of this rule. (3-29-10)

b. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 024.02.h. and 024.02.i. of this rule), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph 024.01.a., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 024.02.c. of this rule) or standardized benefit Plan F (as described in Paragraph 024.02.e. of this rule). (3-29-10)

c. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Subsection 024.03 and in Section 031 of this rule. (4-11-19)

d. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 022.02 and 022.03 of this rule; or, in the case of plans K or L, in Paragraphs 024.02.h. and 024.02.i. of this rule and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of benefit. (3-29-10)

e. In addition to the benefit plan designations required in Paragraph 024.01.d., an issuer may use other designations to the extent permitted by law. (3-29-10)

02. Make-up of 2010 Standardized Benefit Plans. (3-29-10)

a. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Subsection 022.02 of this rule. (3-29-10)

b. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Paragraph 022.03.a. of this rule. (3-29-10)

c. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03. a., 022.03.c., 022.03.d., and 022.03.f of this rule, respectively. (3-29-10)

d. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Subsection 022.02 of this rule), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f. of this rule, respectively. (3-29-10)

e. Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f. of this rule, respectively. (3-29-10)

f. Standardized Medicare supplement Plan F With High Deductible shall include only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 024.02.f.ii. (3-29-10)

i. The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f. of this rule, respectively. (3-29-10)

ii. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars (\$1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services 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 (\$10). (4-11-19)

g. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.e., and 022.03.f. of this rule, respectively. Effective January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020. (4-11-19)

h. Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following: (3-29-10)

i. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period. (3-29-10)

ii. Part A Hospital Coinsurance ninety-first through one hundred fiftieth day: Coverage of one hundred percent (100%) 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; (3-29-10)

iii. Part A Hospitalization After One Hundred Fiftieth Day: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) 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 (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (3-29-10)

iv. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph 024.02.h.x. (3-29-10)

v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) 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 Subparagraph 024.02.h.x. (3-29-10)

vi. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph 024.02.h.x. (3-29-10)

vii. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph 024.02.h.x. (3-29-10)

viii. Part B Cost Sharing: Except for coverage provided in Subparagraph 024.02.h.ix., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 024.02.h.x. (3-29-10)

ix. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (3-29-10)

x. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) 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 (\$4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. (3-29-10)

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following: (3-29-10)

i. The benefits described in Subparagraphs 024.02.h.i. through 024.02.h.iii., and 024.02.h.ix. (3-29-10)

ii. The benefits described in Subparagraphs 024.02.h.iv. through 024.02.h.viii. but substituting seventy-five percent (75%) for fifty percent (50%); and (3-29-10)

iii. The benefit described in Subparagraph 024.02.h.x. but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000). (3-29-10)

j. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.b., 022.03.c., and 022.03.f. of this rule, respectively. (3-29-10)

k. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Subsection 022.02 of this rule, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f. of this rule, respectively, with copayments in the following amounts: (3-29-10)

i. The lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (3-29-10)

ii. The lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. (3-29-10)

03. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. (3-29-10)

025. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are

applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 024 of this rule. (4-11-19)

01. Benefit Requirements. The standards and requirements of Section 024 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions: (4-11-19)

a. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Paragraph 024.02.c. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. (4-11-19)

b. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Paragraph 024.02.e. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. (4-11-19)

c. Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020. (4-11-19)

d. Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Paragraph 024.02.f. of this rule but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible. (4-11-19)

e. The reference to Plans C or F contained in Paragraph 024.01.b. is deemed a reference to Plans D or G for purposes of this section. (4-11-19)

02. Applicability to Certain Individuals. This section applies only to individuals that are newly eligible for Medicare on or after January 1, 2020: (4-11-19)

a. By reason of attaining age sixty-five (65) on or after January 1, 2020; or (4-11-19)

b. By reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020. (4-11-19)

03. Guaranteed Issue for Eligible Persons. For purposes of Subsection 041.05 of this rule, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of Subsection 025.01. (4-11-19)

04. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection 024.02 of this rule. (4-11-19)

026. -- 030. (RESERVED)

031. MEDICARE SELECT POLICIES AND CERTIFICATES.

This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section. (3-29-10)

- 01. Definitions.** For the purposes of Section 031: (4-11-19)
- a.** Complaint. Any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers. (4-5-00)
 - b.** Grievance. 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. (4-5-00)
 - c.** Medicare Select issuer. An issuer offering, or seeking to offer, a Medicare Select policy or certificate. (4-5-00)
 - d.** Medicare Select policy or Medicare Select certificate. Respectively a Medicare supplement policy or certificate that contains restricted network provisions. (4-5-00)
 - e.** Network provider. A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy. (4-5-00)
 - f.** Restricted network provision. Any provision which conditions the payment of benefits, in whole or in part, on the use of network providers. (4-5-00)
 - g.** Service area. The geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy. (4-5-00)
- 02. Authorization to Issue Medicare Select Policy or Certificate.** The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to Section 031 of this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer has satisfied all of the requirements of this rule. (4-11-19)
- 03. Filing Requirements.** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director. (4-5-00)
- 04. Proposed Plan of Operation.** A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information: (4-5-00)
- a.** Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that: (4-5-00)
 - i.** Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community. (4-5-00)
 - ii.** The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals. (4-5-00)
 - iii.** There are written agreements with network providers describing specific responsibilities. (4-5-00)
 - iv.** Emergency care is available twenty-four (24) hours per day and seven (7) days per week. (4-5-00)
 - 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 Subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the

- Medicare Select policy or certificate. (3-29-10)
- b.** A statement or map providing a clear description of the service area. (4-5-00)
 - c.** A description of the grievance procedure to be utilized. (4-5-00)
 - d.** A description of the quality assurance program, including: (4-5-00)
 - i.** The formal organizational structure; (4-5-00)
 - ii.** The written criteria for selection, retention, and removal of network providers; and (4-5-00)
 - iii.** The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted. (4-5-00)
 - e.** A list and description, by specialty, of the network providers. (4-5-00)
 - f.** Copies of the written information proposed to be used by the issuer to comply with Subsection 031.08. (4-11-19)
 - g.** Any other information requested by the director. (4-5-00)
- 05. Proposed Changes to the Plan of Operation.** A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the director at least quarterly. (4-5-00)
- 06. Restrictions.** A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if: (4-5-00)
- a.** The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and (4-5-00)
 - b.** It is not reasonable to obtain services through a network provider. (4-5-00)
- 07. Payment for Full Coverage.** A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers. (4-5-00)
- 08. Full and Fair Disclosure.** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following: (4-5-00)
- a.** An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with: (4-5-00)
 - i.** Other Medicare supplement policies or certificates offered by the issuer; and (4-5-00)
 - ii.** Other Medicare Select policies or certificates. (4-5-00)
 - 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. (4-5-00)
 - c.** A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. 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. (4-11-06)

- d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage. (4-5-00)
- e. A description of limitations on referrals to restricted network providers and to other providers. (4-5-00)
- f. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer. (4-5-00)
- g. A description of the Medicare Select issuer's quality assurance program and grievance procedure. (4-5-00)

09. Medicare Select Policy or Certificate. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection 031.08 and that the applicant understands the restrictions of the Medicare Select policy or certificate. (4-11-19)

10. Complaints and Grievances. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. (4-5-00)

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage. (4-5-00)

b. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer. (4-5-00)

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. (4-5-00)

d. If a grievance is found to be valid, corrective action shall be taken promptly. (4-5-00)

e. All concerned parties shall be notified about the results of a grievance. (4-5-00)

f. The issuer shall report no later than each March 31 to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances. (4-5-00)

11. Initial Purchase. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer. (4-5-00)

12. Comparable or Lesser Benefits. (4-5-00)

a. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months. (4-5-00)

b. For the purposes of Subsection 031.12, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) 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. (4-11-19)

13. Continuation of Coverage. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be re-authorized under law or its substantial amendment. (3-29-10)

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the insurer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability. (4-5-00)

b. For the purposes of Subsection 031.13, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) 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. (4-11-19)

14. Requests for Data. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program. (4-5-00)

032. -- 035. (RESERVED)

036. OPEN ENROLLMENT.

01. Offer of Coverage. (3-29-17)

a. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with: (3-29-17)

i. The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. (3-29-17)

ii. January 1, 2018 or the first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, whichever is later, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or (3-29-17)

iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration. (3-29-17)

b. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under Paragraph 036.01.a. without regard to age. (4-11-19)

02. Treatment of Preexisting Conditions. (3-29-17)

a. If an applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition. (4-11-19)

b. If the applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary of Health and Human Services shall specify the manner of the reduction under this Subsection. (4-11-19)

c. Except as provided in Paragraphs 036.02.a. and 02.b., and Sections 041 and 081, nothing in this rule shall be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective. (4-11-19)

03. Discrimination in Pricing. An issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 036.01, except on the basis of the following criteria: (4-11-19)

a. Issue age; and (3-29-17)

b. Smoking or tobacco use. (3-29-17)

037. -- 040. (RESERVED)

041. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue. (4-5-00)

a. Eligible persons are those individuals described in Subsection 041.02 who seek to enroll under the policy during the period specified in Subsection 041.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy. (4-11-19)

b. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 041.05 that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. (4-11-19)

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 041.02: (4-11-19)

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; (4-5-00)

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan: (4-11-06)

i. The certification of the organization or plan under this part has been terminated; (4-11-06)

ii. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; (4-11-06)

iii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary of Health and Human Services, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; (4-11-06)

- iv. The individual demonstrates, in accordance with guidelines established by the Secretary of Health and Human Services: (3-29-10)
- (a) That the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (3-29-10)
- (b) The organization, or agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (3-29-10)
- (c) The individual meets such other exceptional conditions as the Secretary may provide. (3-29-10)
- c. The individual is enrolled with: (4-5-00)
- i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); (5-3-03)
- ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (4-5-00)
- iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (5-3-03)
- iv. An organization under a Medicare Select policy; and (4-5-00)
- d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 041.02.b. (4-11-19)
- e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (4-5-00)
- i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or (4-5-00)
- ii. Of other involuntary termination of coverage or enrollment under the policy; (4-5-00)
- iii. The issuer of the policy substantially violated a material provision of the policy; or (4-5-00)
- iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. (4-5-00)
- f. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and (4-11-06)
- g. The subsequent enrollment under Paragraph 041.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or (4-11-19)
- h. The individual, upon first becoming eligible for benefits under Part A of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment. (4-11-06)
- i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time

of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 041.05.e. (4-11-19)

03. Guaranteed Issue Time Periods. (5-3-03)

a. In the case of an individual described in Paragraph 041.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; (4-11-19)

b. In the case of an individual described in Paragraphs 041.02.b., 041.02.c., 041.02.f., or 041.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated; (4-11-19)

c. In the case of an individual described in Paragraph 041.02.e., the guaranteed issue period begins on the earlier of: (4-11-19)

i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (5-3-03)

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated; (5-3-03)

d. In the case of an individual described in Paragraph 041.02.b. and Subparagraph 041.02.e.iii., and Subparagraph 041.02.e.iv., Paragraph 041.02.f., or 041.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and (4-11-19)

e. In the case of an individual described in Paragraph 041.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and (4-11-19)

f. In the case of an individual described in Subsection 041.02 but not described in the preceding provisions of Subsection 041.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date. (4-11-19)

04. Extended Medigap Access for Interrupted Trial Periods. (5-3-03)

a. In the case of an individual described in Paragraph 041.02.f. (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 041.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 041.02.f.; (4-11-19)

b. In the case of an individual described in Paragraph 041.02.h. (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph 041.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Paragraph 041.02.h.; and (4-11-19)

c. For purposes of Paragraphs 041.02.f. and 041.02.h., no enrollment of an individual with an organization or provider described in Paragraph 041.02.f. or with a plan or in a program described in Paragraph 041.02.h. may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the

date on which the individual first enrolled with such an organization, provider, plan or program. (4-11-19)

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under: (4-11-06)

a. Paragraphs 041.02.a. through 041.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. (4-11-19)

b. Subject to Paragraph 041.05.c., Paragraph 041.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 041.05.a. (4-11-19)

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 041.05 is: (4-11-19)

i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (4-11-06)

ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer; (4-11-06)

d. Paragraph 041.02.h. shall include any Medicare supplement policy offered by any issuer. (4-11-19)

e. Paragraph 041.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. (4-11-19)

06. Notification Provisions. (4-5-00)

a. At the time of an event described in Subsection 041.02 of this rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice shall be communicated contemporaneously with the notification of termination. (4-11-19)

b. At the time of an event described in Subsection 041.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment. (4-11-19)

07. Discrimination in Pricing. With respect to eligible persons, an issuer shall not discriminate in the pricing of a Medicare supplement policy or certificate issued pursuant to Subsection 041.01, except on the basis of the following criteria: (4-11-19)

a. Issue age; and (3-29-17)

b. Smoking or tobacco use. (3-29-17)

042. -- 045. (RESERVED)

046. STANDARDS FOR CLAIMS PAYMENT.

01. Compliance. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by: (3-29-10)

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; (4-5-00)

b. Notifying the participating physician or supplier and the beneficiary of the payment determination; (4-5-00)

c. Paying the participating physician or supplier directly; (4-5-00)

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; (4-5-00)

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and (4-5-00)

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers. (4-5-00)

02. Certification. Compliance with the requirements set forth in Subsection 046.01 shall be certified on the Medicare supplement insurance experience reporting form. (4-11-19)

047. -- 050. (RESERVED)

051. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards. (4-5-00)

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form. (4-5-00)

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or (4-5-00)

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies; (4-5-00)

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization shall not include: (4-11-06)

i. Home office and overhead costs; (4-11-06)

ii. Advertising costs; (4-11-06)

iii. Commissions and other acquisition costs; (4-11-06)

iv. Taxes; (4-11-06)

v. Capital costs; (4-11-06)

vi. Administrative costs; and (4-11-06)

vii. Claims processing costs. (4-11-06)

c. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations shall, at a minimum, account for: (3-29-17)

i. Lapse rates; (3-29-17)

ii. Medical trend and rationale for trend; (3-29-17)

iii. Assumptions regarding future premium rate revisions; and (3-29-17)

iv. Interest rates for discounting and accumulating. (3-29-17)

d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., 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. (4-11-19)

e. For policies issued prior to July 1, 1992, expected claims in relation to premiums shall meet: (4-5-00)

i. The originally filed anticipated loss ratio when combined with the actual experience since inception; (4-5-00)

ii. The appropriate loss ratio requirement from Subparagraphs 051.01.a.i. and 051.01.a.ii. when combined with actual experience beginning with July 1, 1992 to date; and (4-11-19)

iii. The appropriate loss ratio requirement from Subparagraphs 051.01.a.i. and 051.01.a.ii. over the entire future period for which the rates are computed to provide coverage. (4-11-19)

02. Refund or Credit Calculation. (4-5-00)

a. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible by the Internet website at <https://doi.idaho.gov> for each type in a standard Medicare supplement benefit plan. (4-11-06)

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is required. The refund calculation shall 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 shall be excluded. (4-5-00)

c. For the purpose of Section 051, policies or certificates issued prior to July 1, 1992, the issuer shall 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 July 1, 1992. The first report shall be due by May 31, 1994. (4-11-19)

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based. (4-5-00)

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 1, 1992, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state: (4-5-00)

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing. (4-5-00)

b. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date. (4-5-00)

c. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by Section 051. (4-11-19)

d. 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 shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate. (4-5-00)

04. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 1, 1992 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 shall be furnished in a manner deemed appropriate by the director. (4-5-00)

052. -- 055. (RESERVED)

056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Filing of Policy Forms. (3-29-10)

a. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (3-29-10)

b. An issuer shall 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 director in the state in which the policy or certificate was issued. (3-29-10)

02. Filing of Premium Rates. (3-29-10)

a. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in

accordance with the filing requirements and procedures prescribed by the director. (3-29-10)

b. Except as provided in Subsection 051.03, the insured shall not receive more than one (1) rate increase in any twelve (12) month period. (4-11-19)

03. Except as provided in Paragraph 056.03.a., an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (4-11-19)

a. An issuer may offer, with the approval of the director, up to three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases: (3-29-17)

i. The inclusion of new or innovative benefits; (4-5-00)

ii. The addition of either direct response or agent marketing methods; (4-5-00)

iii. The addition of either guaranteed issue or underwritten coverage; (4-5-00)

b. For the purposes of Section 056, “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. (4-11-19)

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 056.04.a., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months. (4-11-19)

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state. (4-5-00)

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 056.04.a. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate. (4-11-19)

c. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of Subsection 056.04. (4-11-19)

d. A change in the rating structure or methodology shall be considered a discontinuance under this Subsection 056.04 unless the issuer complies with the following requirements: (4-11-19)

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (4-5-00)

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 director may approve a change to the differential which is in the public interest. (4-5-00)

05. Experience of Policy Forms. (4-5-00)

a. Except as provided in Paragraph 056.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 051. (4-11-19)

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation. (4-5-00)

c. The experience of all policy forms or certificate forms for standardized Medicare supplement benefit plans of the same type shall be combined for purposes of the rate change filing. Generally, any applicable percentage increase shall be filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. (3-29-17)

06. Attained Age Rating Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho July 1, 1992, under IDAPA 18.04.10, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act,” sold to residents of this state and all those sold on or after January 1, 1995, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. This rule explicitly authorizes both issue age ratings and community ratings consistent with the prohibition of attained age ratings and allows companies to resubmit for approval issue age ratings previously rejected. (3-29-10)

07. Rating by Area and Gender Prohibited. With respect to Medicare supplement policies that conform to the Standard Benefit Plans developed by the National Association of Insurance Commissioners and adopted by the State of Idaho, July 1, 1992, under IDAPA 18.04.10, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act,” sold to residents of this State and all those sold on or after January 1, 1999, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose. (3-29-10)

08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this rule, sold to residents of this State on or after January 1, 2018: (3-29-17)

a. Any rate adjustments will be uniform between 1990 Standardized and 2010 Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. (3-29-17)

b. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 036, or guaranteed issue, per Section 041, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue. (4-11-19)

c. For issue-ages sixty-five (65) and greater, the filed rate for any given age must not exceed the rate for any higher issue-age, similarly rated individual. (3-29-17)

d. For issue-ages sixty-four (64) or less, the premium shall not exceed one hundred fifty percent (150%) of the premium for an issue-age sixty-five (65), similarly rated individual, while the individual’s attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) shall be charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. (3-29-17)

e. For any given age, the rating by the issuer shall not differentiate on the basis of the reason for eligibility for Medicare Part B. (3-29-17)

057. -- 060. (RESERVED)

061. PERMITTED COMPENSATION ARRANGEMENTS.

01. Commissions. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. (4-5-00)

02. Compensation in Subsequent Years. The commission or other compensation provided in subsequent renewal years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years. (4-11-06)

03. Renewal Compensation. No issuer or other entity shall provide compensation to its agent or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced. (4-5-00)

04. Compensation. For purposes of Section 061, compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder's fees. (4-11-19)

062. -- 065. (RESERVED)

066. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules. (4-5-00)

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums. (3-29-10)

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy. (4-5-00)

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import. (4-5-00)

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations." (4-5-00)

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto, stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. (3-29-10)

f. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed jointly by the National Association of Insurance Commissions and the Centers for Medicare & Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. (4-11-06)

g. For the purposes of Section 066, "form" means the language, format, type size, type proportional

spacing, bold character, and line spacing. (4-11-19)

02. Notice Requirements. (4-5-00)

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall: (4-5-00)

i. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and (4-5-00)

ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare. (4-5-00)

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. (4-5-00)

c. The notices shall not contain or be accompanied by any solicitation. (4-5-00)

03. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (4-11-06)

04. Outline of Coverage Requirements for Medicare Supplement Policies. (4-5-00)

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and (4-5-00)

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) 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.” (4-5-00)

c. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated. (3-29-10)

05. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies. (3-29-10)

a. Any accident and sickness insurance policy or certificate other than Medicare supplement policy and policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Paragraph 001.02.b. of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain

the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.” (3-29-10)

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph 066.04.a. shall disclose, using the applicable NAIC Model Regulation as incorporated by reference in Section 004 of this rule and referenced as Appendix C located at the website: <https://doi.idaho.gov>. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate. (4-11-19)

067. -- 070. (RESERVED)

071. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms shall 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 policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used. (4-11-06)

02. Statements. (4-5-00)

a. You do not need more than one (1) Medicare supplement policy. (4-5-00)

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (4-5-00)

c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (4-5-00)

d. 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 (24) months. You must request this suspension within ninety (90) 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 (90) 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. (4-11-06)

e. 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 policy can be suspended, if requested, while you are covered under the employer or union-based group health 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 ninety (90) days of losing your employer or union-based 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. (4-11-06)

f. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), 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). (4-11-06)

03. Questions. See Idaho Appendix A at the end of this rule. (3-29-10)

04. Agents. Agents shall list any other health insurance policies they have sold to the applicant. (4-5-00)

a. List policies sold which are still in force. (4-5-00)

b. List policies sold in the past five (5) years which are no longer in force. (4-5-00)

05. Direct Response Issuer. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. (4-5-00)

06. Notice Regarding Replacement of Medicare Supplement Coverage. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage. (4-5-00)

07. SHIBA and Consumer Assistance Link. The notice required in Subsection 071.06 for an issuer shall be provided in substantially the following form based on the NAIC Model Regulation as incorporated by reference in Section 004 of this rule, which includes NAIC Appendixes A, B, and C and all other outlines of coverage and specific plan designs which can be accessed on the Idaho Department of Insurance website at <https://doi.idaho.gov/displaypdf?ID=18.01.54&cat=Laws>. To obtain a copy of the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. (4-11-19)

072. FILING REQUIREMENTS FOR ADVERTISING.

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by the director. (4-5-00)

073. STANDARDS FOR MARKETING.

01. Issuer. An issuer, directly or through its producers, shall: (4-5-00)

a. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. (4-5-00)

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (4-5-00)

c. Display prominently by type, stamp, or other appropriate means, on the first page of the policy the following:

“Notice to buyer: This policy may not cover all of your medical expenses.” (4-5-00)

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance. (4-5-00)

e. Establish auditable procedures for verifying compliance with this Subsection 073.01. (4-11-19)

02. Prohibited Acts and Practices. In addition to the practices prohibited in Chapter 13, Title 41, Idaho Code, the following acts and practices are prohibited: (4-5-00)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer. (4-5-00)

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. (4-5-00)

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (4-5-00)

03. Prohibited Terms. The terms “Medicare supplement,” “Medigap,” “Medicare wrap-around,” and words of similar import shall not be used unless the policy is issued in compliance with this rule. (3-29-10)

074. -- 075. (RESERVED)

076. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.

In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited. An issuer shall 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. (4-11-06)

077. REPORTING OF MULTIPLE POLICIES.

01. Reporting. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate: (4-5-00)

a. Policy and certificate number, and (4-5-00)

b. Date of issuance. (4-5-00)

02. Grouping by Individual Policyholder. The items set forth above must be grouped by individual policyholder. (4-5-00)

078. -- 080. (RESERVED)

081. PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

01. Waiving of Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy. (4-5-00)

02. Replacing Policy. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at last six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. (4-5-00)

082. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.

This section applies to all policies with policy years beginning on or after May 21, 2009. (3-29-10)

- 01. Prohibited Provisions.** An issuer of a Medicare supplement policy or certificate: (3-29-10)
- a.** Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and (3-29-10)
 - b.** Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual. (3-29-10)
- 02. Denial of Coverage.** Nothing in Subsection 082.01 shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from: (4-11-19)
- a.** Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or (3-29-10)
 - b.** Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group). (3-29-10)
- 03. Genetic Testing.** An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test. (3-29-10)
- 04. Payment.** Subsection 082.03 shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection 082.01. of this rule. (4-11-19)
- 05. Information.** For purposes of carrying out Subsection 082.04, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose. (4-11-19)
- 06. Allowed Genetic Testing.** Notwithstanding Subsection 082.03, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met: (4-11-19)
- a.** The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or rules for the protection of human subjects in research. (3-29-10)
 - b.** The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:
 - i.** Compliance with the request is voluntary; and (3-29-10)
 - ii.** Non-compliance will have no effect on enrollment status or premium or contribution amounts. (3-29-10)
 - c.** No genetic information collected or acquired under Subsection 082.06 shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate. (4-11-19)
 - d.** The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under Subsection 082.06, including a description of the activities conducted. (4-11-19)

e. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under Subsection 082.06. (4-11-19)

f. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes. (3-29-10)

g. An issuer of a Medicare supplement policy or certificate shall not request, require or purchase genetic information with respect to any individual prior to such individual’s enrollment under the policy in connection with such enrollment. (3-29-10)

h. If an issuer of Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, such request, requirement, or purchase shall not be considered a violation of Paragraph 082.06.g. if such request, requirement, or purchase is not in violation of Paragraph 082.06.f. (4-11-19)

07. Definitions. For the purposes of this section only; (3-29-10)

a. “Issuer of a Medicare supplement policy or certificate” includes third-party administrator, or other person acting for or on behalf of such issuer. (3-29-10)

b. “Family member” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual. (3-29-10)

c. “Genetic information” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual. (3-29-10)

d. “Genetic services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education. (3-29-10)

e. “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. (3-29-10)

f. “Underwriting purposes” means: (3-29-10)

i. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy; (3-29-10)

ii. The computation of premium or contribution amounts under the policy; (3-29-10)

iii. The application of any preexisting condition exclusion under the policy; and (3-29-10)

iv. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. (3-29-10)

083. -- 999. (RESERVED)

IDAHO APPENDIX A

Sample Consumer Questionnaire

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.

To the best of your knowledge:

1. Did you turn 65 in the last six (6) months?
2. Did you enroll in Medicare Part B in the last six (6) months?
 - a. If so, what is the effective date?
3. 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.
4. Will Medicaid pay your premiums for this Medicare supplement policy?
5. Do you receive any benefits from Medicaid **OTHER THAN** payments toward your Medicare Part B premium?
6. If you had coverage from any Medicare plan other than original Medicare within the past sixty-three (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.
7. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
8. Was this your first time in this type of Medicare plan?
9. Did you drop a Medicare supplement policy to enroll in the Medicare plan?
10. Do you have another Medicare supplement policy in force?
 - a. If so, with what company and what plan do you have?
 - b. If so, so you intend to replace your current medicare supplement policy with this policy?
11. Have you had coverage under any other health insurance within the past sixty-three (63) days?
 - a. If so, with what company and what kind of policy?
 - b. What are your dates of coverage under the other policy?

**IDAPA 18
TITLE 04
CHAPTER 11**

18.04.11 – LONG-TERM CARE INSURANCE MINIMUM STANDARDS

000. LEGAL AUTHORITY.

This rule is issued pursuant to the authority vested in the director under Chapters 2 and 46, Title 41, Idaho Code and Chapter 52, Title 67, Idaho Code. (4-5-00)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.11, rule to implement the “Long-Term Care Insurance Minimum Standards.” (4-5-00)

02. Purpose. The purpose of this rule is to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance. (4-5-00)

03. Scope and Applicability. Except as otherwise specifically provided, this rule applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by Insurers, Fraternal Benefit Societies, Managed Care Organizations and all similar organizations; certain provisions of this rule apply only to qualified long-term care insurance. Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: (3-30-01)

a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services; (3-30-01)

b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or (3-30-01)

c. Benefits under the policy may commence after the policyholder has reached Social Security’s normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services. (3-30-01)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General,” Sections 000 through 099, General Provisions. (3-30-07)

004. INCORPORATION OF DOCUMENTS BY REFERENCE.

01. Forms. Documents incorporated by reference may be obtained from the Idaho Department of Insurance website at <http://www.doi.idaho.gov>. (3-25-16)

02. Documents Incorporated by Reference. This rule incorporates by reference the following documents, appendices, and attachments of the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation 641. The Model Regulation is available from the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662 and from the Idaho Department of Insurance. (3-25-16)

- a. Rescission Reporting Form for Long-Term Care, Appendix A. (3-25-16)
- b. Personal Worksheet, Appendix B. (3-25-16)
- c. Things You Should Know Before You Buy Long-Term Care Insurance, Appendix C. (3-25-16)
- d. Suitability Letter, Appendix D. (3-25-16)
- e. Claims Denial Reporting Form, Appendix E. (3-25-16)
- f. Instructions, Appendix F. (3-25-16)
- g. Replacement and Lapse Reporting Form, Appendix G. (3-25-16)
- h. Outline of Coverage. (3-25-16)
- i. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance, Attachment I. (3-25-16)
- j. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance, Attachment II. (3-25-16)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

- 01. Office Hours.** The Department of Insurance is open from 8 a.m. to 5pm. Except Saturday. Sunday and legal holidays. (3-30-07)
- 02. Mailing Address.** The department's mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)
- 03. Street Address.** The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (3-30-07)
- 04. Web Site Address.** The department's website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provision of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions must satisfy definitions as amended by the U.S. Treasury Department and the following requirements: (4-5-00)

- 01. Activities of Daily Living.** At least bathing, continence, dressing, eating, toileting, and transferring. (4-5-00)
- 02. Acute Condition.** The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his health status. (4-5-00)
- 03. Adult Day Care.** A program for six (6) or more individuals, of 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 home. (4-5-00)

04. Bathing. 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. (4-5-00)

05. Cognitive Impairment. 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. (4-5-00)

06. Continence. 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). (4-5-00)

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. (4-5-00)

08. Eating. 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. (4-5-00)

09. Exceptional Increase. Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. (3-30-01)

a. Except as provided in Section 025, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. (3-30-07)

b. The director 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. (3-30-01)

c. The director, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs. (3-30-01)

10. Hands-On Assistance. Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. (4-5-00)

11. Home Health Care Services. Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services. (4-5-00)

12. Incidental. As used in Subsection 025.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue. (3-30-07)

13. Medicare. “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. (4-5-00)

14. Mental or Nervous Disorder. Shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (4-5-00)

15. Personal Care. The provision of hands-on services to assist an individual with activities of daily living. (4-5-00)

16. Qualified Actuary. Means a member in good standing of the American Academy of Actuaries. (3-30-01)

17. Similar Policy Forms. Means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, 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: (3-30-01)

- a. Institutional long-term care benefits only; (3-30-01)
- b. Non-institutional long-term care benefits only; or (3-30-01)
- c. Comprehensive long-term care benefits. (3-30-01)

18. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and Other Services. Skilled Nursing Care, Personal Care, Home Care, Specialized Care, Assisted Living Care and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered. (3-30-07)

19. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. (4-5-00)

20. Transferring. Moving into or out of a bed, chair, or wheelchair. (4-5-00)

21. All Providers of Services. All providers of services including but not limited to Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, Personal Care Facility, Specialized Care Providers, Assisted Living Facility, and Home Care Agency shall 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 shall also state what requirements a provider must meet in lieu of licensure, certification or registration when 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 when the state licenses, certifies or registers the provider of services under another name. (3-30-07)

011. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 014 of this rule. (3-30-07)

a. A policy issued to an individual shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable.” (4-5-00)

b. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis. (4-5-00)

c. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate. (4-5-00)

d. The term “level premium” may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy. (3-30-01)

e. In addition to the other requirements of Subsection 011.01, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. (3-30-07)

02. Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: (4-5-00)

- a.** Preexisting conditions or diseases; (4-5-00)
- b.** Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer’s Disease; (4-5-00)
- c.** Alcoholism and drug addiction; (4-5-00)
- d.** Illness, treatment, or medical condition arising out of: (4-5-00)
 - i.** War or act of war (whether declared or undeclared); (4-5-00)
 - ii.** Participation in a felony, riot, or insurrection; (4-5-00)
 - iii.** Service in the armed forces or units auxiliary thereto; (4-5-00)
 - iv.** Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or (4-5-00)
 - v.** Aviation (this exclusion applies only to non-fare-paying passengers). (4-5-00)
- e.** 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’ compensation, 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; (4-5-00)
- f.** Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or (4-5-00)
- g.** In the case of a qualified long-term care insurance contract, 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. (4-5-00)
- h.** Subsection 011.02 is not intended to prohibit exclusions and limitations by type of provider. However, no long term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions: (3-30-07)
 - i.** When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or (3-30-07)
 - ii.** When the state other than the state of policy issue licenses, certifies or registers the provider under another name. For purposes of this Subsection 011.02.h. “state of policy issue” means the state in which the individual policy or certificate was originally issued. (3-30-07)
 - iii.** Subsection 011.02 is not intended to prohibit territorial limitations. (3-30-07)

03. Extension of Benefits. Termination of long-term care insurance shall 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. (4-5-00)

04. Continuation or Conversion. (4-5-00)

a. Group long-term care insurance issued in this state on or after the effective date of Section 011 shall provide covered individuals with a basis for continuation or conversion of coverage. (3-30-07)

b. For the purposes of Section 011, “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. 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. The director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. (3-30-07)

c. For the purposes of Section 011, “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 (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. (3-30-07)

d. For the purposes of Section 011, “converted policy” means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where 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 director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. (3-30-07)

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually. (4-5-00)

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured’s age at inception of coverage under the group policy replaced. (4-5-00)

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where: (4-5-00)

i. Termination of group coverage resulted from an individual’s failure to make any required payment of premium or contribution when due; or (4-5-00)

ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage: (4-5-00)

(1) Providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided by the terminating coverage; and (4-5-00)

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 011.04.f. (3-30-07)

h. Notwithstanding any other provision of Section 011, 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 (100%) of incurred expenses. The provision shall 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. (3-30-07)

i. 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, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. (4-5-00)

j. Notwithstanding any other provision of Section 011, an insured individual whose eligibility for group long-term care coverage is based upon his relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. (3-30-07)

k. For the purposes of Section 011 a "managed-care plan" is 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. (3-30-07)

05. 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 insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy: (4-5-00)

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (4-5-00)

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services. (4-5-00)

06. Premium Changes. (4-5-00)

a. The premium charged to an insured shall not increase due to either: (4-5-00)

i. The increasing age of the insured at ages beyond sixty-five (65); or (4-5-00)

ii. The duration the insured has been covered under the policy. (4-5-00)

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 032, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. (3-30-07)

c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 032, the initial annual premium shall be based on the reduced benefits. (3-30-07)

07. Electronic Enrollment for Group Policies. (4-5-00)

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by an producer or insurer shall be deemed satisfied if: (3-30-07)

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee; (4-5-00)

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and (4-5-00)

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. (4-5-00)

b. The insurer shall make available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (4-5-00)

012. (RESERVED)

013. UNINTENTIONAL LAPSE.

01. Notice Before Lapse or Termination. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following: (4-5-00)

a. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) 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. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one (1) person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) 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 (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years. (4-5-00)

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection 013.01.a. need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant. (3-30-07)

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 insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection 013.01.a., at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing. (3-30-07)

02. Reinstatement. In addition to the requirement in Subsection 013.01, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate. (3-30-07)

014. REQUIRED DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies shall contain a renewability provision. (3-30-01)

a. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. (3-30-01)

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that the premium rates may change. (3-30-01)

02. Riders and Endorsements. Except for riders or endorsements by which the insurer 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 date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement. (4-5-00)

03. 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 shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (4-5-00)

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.” (4-5-00)

05. 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 in Section 41-4605(4)(b)(i), Idaho Code, shall 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 shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.” (3-30-07)

06. Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. Subsection 014.06 shall not apply to qualified long-term care insurance contracts. (3-30-07)

07. Benefit Triggers. 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 policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits.” Any additional benefit triggers shall also be explained. If these triggers differ for different benefits, 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, this too shall be specified. (4-5-00)

08. Qualified Contracts. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is intended to be a qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code of 1986, as amended. (3-30-07)

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 035 that the policy is not intended to be a qualified long-term care insurance contract. (3-30-07)

10. Required Disclosure of Rating Practices to Consumers. (3-30-01)

a. Subsection 014.10 shall apply as follows: (3-30-07)

i. Except as provided in Subsection 014.10.a.ii., Subsection 014.10 applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. (3-30-07)

ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 014.10 shall apply on the policy anniversary following January 1, 2002. (3-30-07)

b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in Subsection 014.10.b. to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all information listed in Subsection 014.10.b. to the applicant no later than at the time of delivery of the policy or certificate. (3-30-07)

i. A statement that the policy may be subject to rate increases in the future; (3-30-01)

ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision; (3-30-01)

iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and (3-30-01)

iv. A general explanation for applying premium rate or rate schedule adjustments that shall include, a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 014.10.b.ii., if the premium rate or rate schedule is changed. (3-30-07)

c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies: (3-30-01)

i. The policy forms for which premium rates have been increased; (3-30-01)

ii. The calendar years when the form was available for purchase; and (3-30-01)

iii. 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. (3-30-01)

d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. (3-30-01)

e. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to acquisition. (3-30-01)

f. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of Subsection 014.10 or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subsection 014.10.c. (3-30-07)

g. If the acquiring insurer in Subsection 014.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from insurers referenced in Subsection 014.10.f., the acquiring insurer must make all disclosures required by Subsection 014.10.c., including disclosure of the earlier rate increase referenced in Subsection 014.10.f. (3-25-16)

h. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsections 014.10.b. and 014.10.c. If because of the method of application the applicant cannot sign an acknowledgement at the

time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate. (3-30-07)

i. An insurer shall use the forms in Appendices B and F to comply with the disclosure requirements of Subsection 014.10.b. and Subsection 014.10.h. (3-25-16)

j. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection 014.10.b., when the increase is implemented. (3-30-07)

015. PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

01. Health Conditions. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant. (4-5-00)

02. Medication. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in the application were known by the insurer, or should have been known 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 shall not be rescinded for that condition. (4-5-00)

03. Non-Guaranteed Issue. Except for policies or certificates which are guaranteed issue: (4-5-00)

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an 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.* (4-5-00)

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the 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 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)* (4-5-00)

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following: (4-5-00)

i. A report of a physical examination; (4-5-00)

ii. An assessment of functional capacity; (4-5-00)

iii. An attending physician's statement; or (4-5-00)

iv. Copies of medical records. (4-5-00)

04. Delivery of Application or Enrollment and Form. A copy of the completed application or enrollment form (whichever is applicable) shall 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. (4-5-00)

05. Record of Rescissions. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance director in the format prescribed by the National Association of Insurance Commissioners in Appendix A. (3-25-16)

016. MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

01. Limitations or Exclusions. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits: (4-5-00)

a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided; (4-5-00)

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; (4-5-00)

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses; (4-5-00)

d. By requiring that a nurse or therapist provide services covered by 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; (4-5-00)

e. By excluding coverage for personal care services provided by a home health aide; (4-5-00)

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; (4-5-00)

g. By requiring that the insured or claimant have an acute condition before home health care services are covered; (4-5-00)

h. By limiting benefits to services provided by Medicare-certified agencies or providers; or (4-5-00)

i. By excluding coverage for adult day care services. (4-5-00)

02. Coverage Equivalency. A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) 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 shall not apply to policies or certificates issued to residents of continuing care retirement communities. (4-5-00)

03. Maximum Coverage. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (4-5-00)

017. REQUIREMENT TO OFFER INFLATION PROTECTION.

01. Inflation Protection Offer. No insurer may offer a long-term care insurance policy unless the insurer 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. Insurers 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 (1) of the following: (4-5-00)

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%); (4-5-00)

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status as 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 (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or (4-5-00)

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit. (4-5-00)

d. With respect to inflation protection for a Partnership policy only: (3-30-07)

i. If the policy is sold to an individual who has not attained age sixty-one (61) as of the date of purchase, the policy must provide some level of automatic compound annual inflation protection; (3-25-16)

ii. If the policy is sold to an individual who has attained age sixty-one (61) but has not attained age 76 as of the date of purchase, the policy must provide some level of automatic annual inflation protection; and (3-25-16)

iii. If the policy is sold to an individual who has attained age seventy-six (76) as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection. (3-30-07)

02. Group Offer. Where the policy is issued to a group, the required offer in Subsection 017.01 shall be made to the group policyholder; except, if the policy is issued to a group defined in Section 41-4603(4)(d), Idaho Code, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder. (3-30-07)

03. Requirements for Life Insurance Policies. The offer in Subsection 017.01 above shall not be required of life insurance policies or riders containing accelerated long-term care benefits. (3-30-07)

04. Outline of Coverage. Insurers shall include the following information in or with the outline of coverage: (4-5-00)

a. 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 shall show benefit levels over at least a twenty (20) year period. (4-5-00)

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. (4-5-00)

c. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure. (4-5-00)

05. Continuation of Inflation Protection. Inflation protection benefit increases under a policy which contains these 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 policy. (4-5-00)

06. Premium Disclosures. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant. (4-5-00)

07. Rejection of Offer. Inflation protection as provided in Subsection 017.01 shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in Subsection 017.07. The rejection may be either in the application or on a separate form. 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 policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection (signature line: _____). (3-30-07)

018. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms shall include the following questions designed to elicit

information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 41-4603(a), Idaho Code, the following questions may be modified only to the extent necessary 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. (3-30-07)

a. Do you have another long-term care insurance policy or certificate in force (including insurance, Fraternal Benefit Societies, Managed Care Organization) or other similar organizations? (4-5-00)

b. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months? (4-5-00)

i. If so, with which company? (4-5-00)

ii. If that policy lapsed, when did it lapse? (4-5-00)

c. Are you covered by Medicaid? (4-5-00)

d. Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)? (4-5-00)

02. Other Policy Disclosures. Producers shall list any other health insurance policies they have sold to the applicant. (3-30-07)

a. List policies sold that are still in force. (4-5-00)

b. List policies sold in the past five (5) years that are no longer in force. (4-5-00)

03. Solicitations Other Than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be in a form based on the NAIC Model Regulation Attachment I. (3-25-16)

04. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be in a form based on the NAIC Model Regulation Attachment II. (3-25-16)

05. Notice of Replacement. Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner. (4-5-00)

06. Life Insurance Policy Replacement. Life insurance policies that accelerate benefits for long-term care shall comply with Section 018 if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of IDAPA 18.03.04, "Replacement of Life Insurance and Annuities." If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements. (3-30-07)

019. REPORTING REQUIREMENTS.

01. Maintenance of Producer Records. Every insurer shall maintain records for each producer of that

producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales, in the format of Appendix G. (3-25-16)

02. Producers Experiencing Lapses and Replacements. Every insurer shall report annually by June 30 the ten percent (10%) of its producer's with the greatest percentages of lapses and replacements as measured by Subsection 019.01. (3-30-07)

03. Purpose of Reports. 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 producer activities regarding the sale of long-term care insurance. (3-30-07)

04. Lapsed Policies. Every insurer shall 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. (4-5-00)

05. Replacement Policies. Every insurer shall 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. (4-5-00)

06. Claims Denied. Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of an applicable preexisting condition, in the format of Appendix E. (3-25-16)

07. Policies and Reports. For purposes of Section 019, "policy" shall mean only long-term care insurance and "report" means on a statewide basis. (3-30-07)

a. Policy means only long-term care insurance; (4-5-00)

b. Claim means any request for payment of benefits under a policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met; (4-5-00)

c. Denied means the insurer refused to pay a claim for any reason; and (4-5-00)

d. Report means on a statewide basis. (4-5-00)

08. Filing. Reports required under Section 019 shall be filed with the Director. (3-30-07)

020. LICENSING.

No producer is authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Producer Licensing. (3-30-07)

021. DISCRETIONARY POWERS OF DIRECTOR.

The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that: (4-5-00)

01. General Requirement. The modification or suspension would be in the best interest of the insureds; the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or (4-5-00)

02. Residential Care Community. 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 (4-5-00)

03. Other Insurance Products. 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. (4-5-00)

022. RESERVE STANDARDS.

01. Acceleration of Benefits Under Life Policies. When 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 shall be determined in accordance with Section 41-612, Idaho Code, Standard Valuation Law – Life Insurance. Claim reserves shall also be established in the case when the policy or rider is in claim status. (4-5-00)

02. Decrement Models. Reserves for policies and riders subject to Section 022 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. (3-30-07)

03. Considerations Impacting Projected Claim Costs. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries. In the development and calculation of reserves for policies and riders subject to Section 022, due regard shall 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: (3-30-07)

- a. Definition of insured events; (4-5-00)
- b. Covered long-term care facilities; (4-5-00)
- c. Existence of home convalescence care coverage; (4-5-00)
- d. Definition of facilities; (4-5-00)
- e. Existence or absence of barriers to eligibility; (4-5-00)
- f. Premium waiver provision; (4-5-00)
- g. Renewability; (4-5-00)
- h. Ability to raise premiums; (4-5-00)
- i. Marketing method; (4-5-00)
- j. Underwriting procedures; (4-5-00)
- k. Claims adjustment procedures; (4-5-00)
- l. Waiting period; (4-5-00)
- m. Maximum benefit; (4-5-00)
- n. Availability of eligible facilities; (4-5-00)
- o. Margins in claim costs; (4-5-00)
- p. Optional nature of benefit; (4-5-00)
- q. Delay in eligibility for benefit; (4-5-00)

- r. Inflation protection provisions; and (4-5-00)
- s. Guaranteed insurability option. (4-5-00)

04. Benefits Not Covered in Section 022. When long-term care benefits are provided other than as in Subsection 022.01 above, reserves shall be determined in accordance with Section 41-608, Idaho Code, “Reserve for Disability Insurance.” (3-30-07)

023. LOSS RATIO.

Section 023 shall apply to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 024 and 025 of this chapter. (3-30-07)

01. Expected Loss Ratios. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including: (4-5-00)

- a. Statistical credibility of incurred claims experience and earned premiums; (4-5-00)
- b. The period for which rates are computed to provide coverage; (4-5-00)
- c. Experienced and projected trends; (4-5-00)
- d. Concentration of experience within early policy duration; (4-5-00)
- e. Expected claim fluctuation; (4-5-00)
- f. Experience refunds, adjustments or dividends; (4-5-00)
- g. Renewability features; (4-5-00)
- h. All appropriate expense factors; (4-5-00)
- i. Interest; (4-5-00)
- j. Experimental nature of the coverage; (4-5-00)
- k. Policy reserves; (4-5-00)
- l. Mix of business by risk classification; and (4-5-00)
- m. Product features such as long elimination periods, high deductibles and high maximum limits. (4-5-00)

02. Policies That Accelerate Benefits. Subsection 023.01 shall not apply to life insurance policies that accelerate benefits for long-term care. 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: (3-30-07)

- 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; (4-5-00)
- b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. (4-5-00)

- c.** The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. (4-5-00)
- i.** Any policy illustration that meets the applicable requirements of the NAIC Life Insurance Illustrations Model Regulation. (3-30-07)
- d.** An actuarial memorandum is filed with the insurance department that includes: (4-5-00)

 - i.** A description of the basis on which the long-term care rates were determined; (4-5-00)
 - ii.** A description of the basis for the reserves; (4-5-00)
 - iii.** A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (4-5-00)
 - iv.** A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; (4-5-00)
 - v.** A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (4-5-00)
 - vi.** The estimated average annual premium per policy and the average issue age; (4-5-00)
 - vii.** A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall 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 shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (4-5-00)
 - 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. (4-5-00)

024. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it shall file with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state. (4-5-00)

- 01. Initial Filing Requirements.** (3-30-01)
- a.** Subsection 024.01 applies to any long-term care policy issued in this state on or after July 1, 2001. (3-30-07)
- b.** An insurer will provide the information listed in Subsection 024.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale. (3-30-07)
- c.** A copy of the disclosure documents required in Section 014. (3-30-07)
- d.** An actuarial certification consisting of at least the following: (3-30-01)

 - i.** 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; (3-30-01)
 - ii.** A statement that the policy design and coverage provided have been reviewed and taken into consideration; (3-30-01)

- iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. (3-30-01)
- e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: (3-30-01)
 - i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; (3-30-01)
 - ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; (3-30-01)
 - iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted; and (3-30-01)
 - 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; (3-30-01)
 - v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; (3-30-01)
 - vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 024.02 based on a standard age distribution; and (3-30-07)
 - vii. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or, (3-30-01)
 - viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. (3-30-01)

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. (3-30-01)

a. In the event the director requests additional information under this provision, the period referred to in Subsection 024.01.b. of this section does not include the period of time during which the insurer is preparing the requested information. (3-30-07)

025. PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increases. This Section 025 shall apply as follows: (3-30-07)

a. Except as provided in Subsection 025.01.b., this section applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. (3-30-07)

b. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603 (4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2002. (3-30-01)

c. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and shall include: (3-30-01)

- i. Information required by Section 014. (3-30-07)
- d. Certification by a qualified actuary that: (3-30-01)
 - 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; and (3-30-01)
 - ii. The premium rate filing is in compliance with the provisions of this Section 025. (3-30-07)
- 02. Actuarial Memorandum.** An actuarial memorandum justifying the rate schedule change request that includes: (3-30-01)
 - a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of 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: (3-30-01)
 - i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date shall be provided separately; (3-30-01)
 - ii. The projections shall include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; (3-30-01)
 - iii. The projections shall demonstrate compliance with Subsection 025.03, and (3-30-07)
 - iv. For exceptional increases; (3-30-01)
 - (1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and (3-30-01)
 - (2) In the event the director determines as provided in Subsection 010.09.c. that offsets may exist, the insurer shall use appropriate net projected experience. (3-30-07)
 - b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse. (3-30-01)
 - c. 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 company have been relied on by the actuary. (3-30-01)
 - d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates. (3-30-01)
 - e. 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 director; and sufficient information for review of the premium rate schedule increase by the director. (3-30-01)
- 03. Premium Rate Schedule Increases.** All premium rate schedule increases shall be determined in accordance with the following requirements: (3-30-01)
 - a. Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. (3-30-01)
 - b. Premium rate schedule increases shall be calculated such 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: (3-30-01)

- i. The accumulated value of the initial earned premium times fifty eight percent (58%); (3-30-01)
 - ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; (3-30-01)
 - iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and (3-30-01)
 - iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 025.03.b.iii. on an earned basis. (3-30-07)
- c. In the event that a policy form has both exceptional and other increases, the values in Subsections 025.03.b.ii. and 025.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. (3-30-07)

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in IDAPA 18.07.07, “Minimum Reserve Standards For Individual And Group Health Insurance Contracts,” Appendix A, IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages. (3-30-01)

04. Projections Filed for Review. For each rate increase that is implemented, the insurer shall file for review by the director updated projections, as defined in Subsection 025.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection 025.13, the projections required by this Subsection 025.04 shall be provided to the policyholder in lieu of filing with the director. (3-30-07)

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 025.02.a., shall be filed for review by the director every five (5) years following the end of the required period in Subsection 025.04. For group insurance policies that meet the conditions in Subsection 025.13, the projections required by Subsection 025.05 shall be provided to the policyholder in lieu of filing with the director. (3-30-07)

06. Actual and Projected Experience. If the director has determined 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 the premium specified in Subsection 025.03, the director may require the insurer to implement any of the following: (3-30-07)

- a. Premium rate schedule adjustments; or (3-30-01)
 - i. Other measures to reduce the difference between the projected and actual experience. (3-30-01)
- b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 025.02.d. and 025.02.e., if applicable. (3-30-07)

07. Contingent Benefit upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file: (3-30-01)

a. A plan, subject to director 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. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 025.08 may be applied; and (3-30-07)

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 025.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 025.03.b.i. and 025.03.b.iii. (3-30-07)

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated: (3-30-01)

a. The rate increase is not the first rate increase requested for the specific policy form or forms; (3-30-01)

b. The rate increase is not an exceptional increase; and (3-30-01)

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse. (3-30-01)

d. In the event significant adverse lapse has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer shall; (3-30-01)

i. Be subject to the approval of the director; (3-30-01)

ii. Be based on actuarially sound principles, but not be based on attained age; and (3-30-01)

iii. Provide that the maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy. (3-30-01)

e. The insurer shall 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 shall be limited to the lesser of: (3-30-01)

i. The maximum rate increase determined based on the combined experience; and (3-30-01)

ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%). (3-30-01)

09. Persistent Practice of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 025.08 of this section, prohibit the insurer from either of the following: (3-30-07)

a. Filing and marketing comparable coverage for a period of up to five (5) years; or (3-30-01)

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. (3-30-01)

10. Exceptions. Subsections 025.01 and 025.09 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 010.12, if the policy complies with all of the following provisions: (3-30-07)

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; (3-30-01)

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: (3-30-01)

i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance; (3-30-01)

ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities; (3-30-01)

iii. IDAPA 18.03.03, Subsection 018.02, “Variable Contracts.” (3-30-01)

11. Exceptions for Disclosure and Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage. (3-30-01)

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes: (3-30-01)

a. A description of the basis on which the long-term care rates were determined; (3-30-01)

b. A description of the basis for the reserves; (3-30-01)

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (3-30-01)

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; (3-30-01)

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (3-30-01)

f. The estimated average annual premium per policy and the average issue age; (3-30-01)

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall 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 shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (3-30-01)

h. 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 claims status. (3-30-01)

13. Exceptions for Association Plans, Premium Rate Schedule Increases Subsections 025.06 and 025.08 shall not apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where: (3-30-07)

a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or (3-30-01)

b. The policyholder, and not the certificateholders, pay a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed. (3-30-01)

026. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing and Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all advertisements shall be retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. (4-5-00)

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement may not be reasonably applied. (4-5-00)

027. STANDARDS FOR MARKETING AND PRODUCER TRAINING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its producers, shall: (3-30-07)

a. Establish marketing procedures and producer training requirements to assure that any marketing activities, including any comparison of policies by its producers will be fair and accurate. (3-30-07)

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (4-5-00)

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "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." (4-5-00)

d. Provide copies of the disclosure forms required in Subsection 014.10. (3-25-16)

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 032.04.b. and if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying period in Subsection 032.04.c. (3-30-07)

f. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required. (4-5-00)

g. Establish auditable procedures for verifying compliance with Subsection 027.01. (3-30-07)

h. At solicitation, provide written notice to the prospective policyholder and certificateholder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. (3-30-01)

i. For long-term care insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Subsection 011.01.c. of this chapter. (3-30-07)

02. Prohibited Practices. In addition to the practices prohibited in Chapter 13, Title 41, Idaho Code, Trade Practices and Frauds, the following acts and practices are prohibited: (3-30-01)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer. (4-5-00)

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. (4-5-00)

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. (3-30-07)

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. (4-5-00)

03. Associations. With respect to the obligations set forth in Subsection 027.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. (3-30-07)

a. The insurer shall file with the insurance department the following material: (4-5-00)

i. The policy and certificate; (4-5-00)

ii. A corresponding outline of coverage; and (4-5-00)

iii. All advertisements to be utilized. (4-5-00)

b. The association shall disclose in any long-term care insurance solicitation: (4-5-00)

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 (4-5-00)

ii. A brief description of the process under which the policies and the insurer issuing the policies were selected. (4-5-00)

c. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members. (4-5-00)

d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer. (4-5-00)

e. The association shall also: (4-5-00)

i. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change; (4-5-00)

ii. Actively monitor the marketing efforts of the insurer and its producers; and (3-30-07)

iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. (4-5-00)

iv. Subsections 027.03.e.i. through 027.03.e.iii. shall not apply to qualified long-term care insurance contracts. (3-30-07)

f. No group long-term care insurance policy or certificate may be issued to an association unless the

insurer files with the state insurance department the information required in Section 027. (3-30-07)

g. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in Section 027. (3-30-07)

h. Failure to comply with the filing and certification requirements of Section 027 constitutes an unfair trade practice in violation of Chapter 13, Title 41, Idaho Code, Trade Practices and Frauds. (3-30-07)

04. Producer Training Requirements. An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for life and disability (accident and health insurance) and has completed a one-time training course and ongoing training every twenty-four (24) months thereafter. The training shall meet the requirements set forth in this Subsection 027.04. Such training requirements may be approved as continuing education course under IDAPA 18.06.04, "Continuing Education." (4-2-08)

a. The one-time training course required by this section shall be no less than eight (8) hours. In addition to the one-time training course, an individual who sells, solicits, or negotiates long-term care insurance shall complete the ongoing training required by this Subsection 027.04, which shall be no less than four (4) hours every twenty four (24) months. (4-2-08)

b. The training required under Subsection 027.04.a. shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership program, including, but not limited to: (3-30-07)

i. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid; (3-30-07)

ii. Available long-term care services and providers; (3-30-07)

iii. Changes or improvements in long-term care services or providers; (3-30-07)

iv. Alternatives to the purchase of private long-term care insurance; (3-30-07)

v. The effect of inflation on benefits and the importance of inflation protection; and (3-30-07)

vi. Consumer suitability standards and guidelines. (3-30-07)

c. The training required by Subsection 027.04. shall not include any sales or marketing information, materials, or training, other than those required by state and federal law. (3-30-07)

d. Insurers subject to this rule shall obtain verification that a producer receives training required by Subsection 027.04 before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the director upon request. An insurer shall maintain records with respect to the training of its producers concerning the distribution of its long-term care Partnership policies that will allow the Department of Insurance to provide assurance to the Division of Medicaid that the producers have received the training as required by Subsection 027.04 and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long term care including Medicaid in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the director upon request. (3-30-07)

e. The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements of this state. (3-30-07)

028. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 028 shall not apply to life insurance

policies that accelerate benefits for long-term care. (3-30-07)

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the “issuer”) shall: (4-5-00)

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; (4-5-00)

b. Train its producers in the use of its suitability standards; and (3-30-07)

c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. (4-5-00)

03. Determination of Standards. To determine whether the applicant meets the standards developed by the issuer; (4-5-00)

a. The producer and issuer shall develop procedures that take the following into consideration: (3-30-07)

i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; (4-5-00)

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 (4-5-00)

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. (4-5-00)

b. The issuer and producer, if involved, shall make reasonable efforts to obtain the information set out in Subsection 028.03. The efforts shall include presentation to the applicant, at or prior to application, the “Long-Term Care Insurance Personal Worksheet.” The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer’s personal worksheet shall be filed with the director. (3-25-16)

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance website. (3-25-16)

c. A completed personal worksheet shall be returned to the issuer prior to the issuer’s consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. (4-5-00)

d. The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is prohibited. (3-30-07)

04. Appropriateness. The issuer shall use the suitability standards it has developed pursuant to Section 028 in determining whether issuing long-term care insurance coverage to an applicant is appropriate. (3-30-07)

05. Use of Standards. Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance. (3-30-07)

06. Disclosure Form. 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” shall be provided. The form shall be in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. (4-5-00)

07. Rejection and Alternatives. 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 shall send the applicant a letter similar to the NAIC Model Regulations, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file. (4-5-00)

08. Reporting. The issuer shall report annually to the director 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 those who chose to confirm after receiving a suitability letter. (4-5-00)

029. 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 insurer shall 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. (4-5-00)

030. AVAILABILITY OF NEW SERVICES OR PROVIDERS.

01. Notification to Policyholder. An insurer shall notify the policyholder of the availability of a new long-term care policy that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date the new policy is made available for sale in this state. (3-30-07)

02. Exceptions to Notification Requirements. Notwithstanding Subsection 030.01, notification is not required for any policy issued prior to the effective date of this Section 030 or to any policyholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers. (3-30-07)

03. New Coverage. The insurer shall make the new coverage available in one of the following ways: (3-30-07)

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; (3-30-07)

b. By exchanging the existing policy or certificate for one with an issue age based on the present 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 shall be based on premiums paid or reserves held for the prior policy or certificate. (3-30-07)

c. By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost of the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or (3-30-07)

d. By an alternative program developed by the insurer that meets the intent of Section 030 if the program is filed with and approved by the Director. (3-30-07)

04. Proprietary Policy. An insurer is not required to notify policyholders of a new proprietary policy created and filed for use in a limited distribution channel. For purposes of this Subsection 030.04, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel. (3-30-07)

05. Exchanges and Not Replacements. Policies issued pursuant to this Section 030. shall be considered exchanges and not replacements. These exchanges shall not be subject to Section 018, and Section 028, and the reporting requirements of Section 019.01. through 019.05. of this rule. (3-30-07)

06. Employer Sponsored Plan. Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection 030.01 shall be made to the offering entity. However, if the policy is issued to a group defined in Section 41-4603 (04) (d), Idaho Code, Long Term Care Insurance Act, the notification shall be made to each certificateholder. (3-30-07)

07. Nothing Shall Prohibit an Insurer From Offering Coverage. Nothing in this Section 030. shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet eligibility requirements, including underwriting and payment of the required premium to add such new services or providers. (3-30-07)

08. Not Applicable to Life Insurance Policies. This Section 030 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-30-07)

031. RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS.

01. Reduction of Coverage. Every long-term care insurance policy and certificate shall 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: (3-30-07)

- a. Reducing the maximum benefit; or (3-30-07)
- b. Reducing the daily, weekly or monthly benefit amount. (3-30-07)
- c. The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes. (3-30-07)

02. Implementing a Reduction in Coverage. The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage. (3-30-07)

03. Determination of Premium for Reduced Coverage. The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. (3-30-07)

04. Limitations for the Reduction of Coverage. The insurer 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. (3-30-07)

05. Notification in Regard to the Possible Lapse of Policy. If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Subsection 013.01.c. of this rule. (3-30-07)

06. Not Applicable to Life Insurance Policies or Riders Containing Accelerated Benefits. This Section 031 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-30-07)

07. Compliance Requirements. The requirements of this Section 031 shall apply to any long-term care policy issued in this state on or after November 1, 2007. Compliance with this Section 031 may be accomplished by policy replacement, exchange or by adding the required provision via amendment or endorsement to the policy. (3-30-07)

032. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 032 does not apply to life insurance policies or riders containing accelerated long-term care benefits. (3-30-07)

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state shall satisfy the following: (4-5-00)

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection 032.04.e. (3-30-07)

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder. (4-5-00)

03. Contingent Benefit. If the offer required to be made under Section 41-4607, Idaho Code, is rejected, the insurer shall provide the contingent benefit upon lapse described in Section 032. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection 032.04.b.i. shall still apply. (3-30-07)

04. Rejection of Offer. After rejection of the offer required under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 032, the insurer shall provide a contingent benefit upon lapse. (3-30-07)

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse. (4-5-00)

b. A contingent benefit on lapse shall be triggered every time an insurer 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 within Subsection 032.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

(3-30-07)

i. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer 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 below based on the insured’s issue age, the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased, and the ratio in Subsection 032.04.d.ii. is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers For A Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Subsection 032.04.b. and where both are triggered, the benefit provided shall be at the option of the insured.

(3-30-07)

c. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b., the insurer shall: (3-30-07)

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; (4-5-00)

ii. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 032.04.e. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.; and (3-30-07)

iii. Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b. shall be deemed to be the election of the offer to convert in Subsection 032.04.c.ii. unless the automatic option in Subsection 032.04.d.iii. applies. (3-30-07)

d. On or before the effective date of a substantial premium increase as defined in Subsection 032.04.b.i., the insurer shall: (3-30-07)

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; (3-30-07)

ii. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) 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 (120) day period referenced in Subsection 032.04.b.i.; and (3-30-07)

iii. Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 032.04.b.i. shall be deemed to be the election of the offer to convert in Subsection 032.04.d.ii. above if the ratio is forty percent (40%) or more. (3-30-07)

e. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, in accordance with Subsection 032.04.b. but not Subsection 032.04.b.i. are described in Subsection 032.04.e. (3-30-07)

i. For purposes of this Subsection 032.04.e., attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); (3-30-07)

ii. For purposes of Subsection 032.04.e., the nonforfeiture benefit shall 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 shall be determined as specified in Subsection 032.04.e.iii.; (3-30-07)

iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer 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 shall not be less than thirty (30) 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 032.04.f.; (3-30-07)

iv. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter. (3-30-01)

v. Notwithstanding Subsection 032.04.e.iv. for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of: (3-30-07)

- (1) The end of the tenth year following the policy or certificate issue date; or (4-5-00)
- (2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. (4-5-00)
- vi. 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. (4-5-00)
- f. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status. (4-5-00)
- g. There shall be no difference in the minimum nonforfeiture benefits as required under Section 032 for group and individual policies. (3-30-07)
- h. For certificates issued on or after the effective date of this Section 032, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section 032 shall not apply. (3-30-07)
- i. The last sentence Subsection 032.03 and Subsection 032.04.b. and Subsection 032.04.d. shall apply to any long-term care insurance policy defined in Section 41-4603(4)(a), Idaho Code one (1) year after adoption. (3-30-07)
- i. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 023 or Section 025, whichever is applicable, treating the policy as a whole. (3-30-07)
- j. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 032.04.b. or 032.04.b.i., a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer. (3-30-07)
- k. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements: (3-30-07)
- i. The nonforfeiture provision shall be appropriately captioned; (4-5-00)
- ii. The nonforfeiture provision shall provide a benefit available in the event of a default on the payment of any premiums and shall 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 contracts filed for review with the Director for the same contract form; and (3-30-07)
- iii. The nonforfeiture provision shall provide at least one (1) of the following: (4-5-00)
- (1) Reduced paid-up insurance; (4-5-00)
- (2) Extended term insurance; (4-5-00)
- (3) Shortened benefit period; or (4-5-00)
- (4) Other similar offerings approved by the Director. (4-5-00)

033. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions of Benefits Payment. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in

the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment. (4-5-00)

02. Activities of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 033.02 as long as they are defined in the policy. Activities of daily living shall include at least the following as defined in Section 010 and in the policy. (3-30-07)

- a. Bathing; (4-5-00)
- b. Continence; (4-5-00)
- c. Dressing; (4-5-00)
- d. Eating; (4-5-00)
- e. Toileting; and (4-5-00)
- f. Transferring. (4-5-00)

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections 033.01 and 033.02. (3-30-07)

04. Determinations of Deficiency. For purposes of Section 033 the determination of a deficiency shall not be more restrictive than: (3-30-07)

- a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or (4-5-00)
- 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. (4-5-00)

05. Assessments. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers. (4-5-00)

06. Appeals. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations. (4-5-00)

07. Effective Date. The requirements set forth in Section 033 shall be effective within twelve (12) months of the effective date of the rule and shall apply as follows: (3-30-07)

- a. Except as provided in Subsection 033.07.b. the provisions of Section 033 apply to a long-term care policy issued in this state on or after the effective date of the rule. (3-30-07)
- b. For certificates issued on or after the effective date of Section 033, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, that was in force at the time this rule became effective, the provisions of Section 033 shall not apply. (3-30-07)

034. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 034 the following definitions apply: (3-30-07)

a. Qualified long-term care services means services that meet the requirements of Section 7702B(a)(1) of the Internal Revenue Code of 1986, as amended, as follows: 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. (3-30-07)

b. Chronically ill individual has the meaning prescribed for this term by 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: (4-5-00)

i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (4-5-00)

ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (4-5-00)

c. The term chronically ill individual shall not include an individual otherwise meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. (4-5-00)

d. Licensed health care practitioner means a physician, as defined in Section 1861(r)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. (4-5-00)

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). (4-5-00)

02. The Chronically Ill. A qualified long-term care insurance contract shall pay 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. (4-5-00)

03. Payments and Conditions. A qualified long-term care insurance contract shall 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 (90) days due to a loss of functional capacity; or to severe cognitive impairment. (3-30-07)

04. Certifications by Professionals. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection 034.03 shall be performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. (3-30-07)

05. Certifications by Carrier. Certification required pursuant to Subsection 034.03 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) 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 (90) day period. (3-30-07)

06. Appeals. Qualified long-term care contracts shall include a clear description of the process for appealing and resolving benefit determinations. (4-5-00)

035. STANDARD FORMAT OUTLINE OF COVERAGE.

Section 035 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. (3-30-07)

01. Format. The outline of coverage shall be a freestanding document, using no smaller than ten (10) point type. 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. (4-5-00)

02. Content. The outline of coverage shall contain no material of an advertising nature. (4-5-00)

03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for the outline of coverage is published on the Department of Insurance website. (3-25-16)

036. REQUIREMENT TO DELIVER SHOPPER’S GUIDE.

01. Approved Format. 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 director, shall be provided to all prospective applicants of a long-term care insurance policy or certificate. (4-5-00)

a. In the case of producer solicitations, a producer must deliver the shopper’s guide prior to the presentation of an application or enrollment form. (3-30-07)

b. In the case of direct response solicitations, the shopper’s guide must be presented in conjunction with any application or enrollment form. (4-5-00)

02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. (4-5-00)

037. PENALTIES.

In addition to any other penalties provided by the laws of this state any insurer and any producer found to have violated any requirement of this state relating to the marketing of such insurance or of IDAPA 18.04.11, “Long-Term Care Insurance Minimum Standards,” shall be subject to an administrative penalty of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars (\$10,000), whichever is greater. (3-30-07)

038. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 12**

18.04.12 – RULES GOVERNING SMALL EMPLOYER HEALTH INSURANCE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapters 2 and 47, Idaho Code. (1-25-95)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.04.12, “Rules Governing Small Employer Health Insurance.” (1-25-95)

02. Scope. The Act and this rule are intended to promote broader spreading of risk in the small employer marketplace. The Act and rule are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this rule. (1-25-95)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-15-02)

004. DEFINITIONS.

As used in this rule: (1-25-95)

01. Associate Member. Associate Member of an employee organization means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. Section 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. Section 1002(37A)), other than the following: (1-25-95)

a. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or (1-25-95)

b. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one (1) of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan). (1-25-95)

02. Geographic Area. Geographic areas are limited to no more than six (6) designated areas, with no area being smaller than a county. (7-1-98)

03. New Entrant. New Entrant means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan. (1-25-95)

04. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of a small employer group or of any member of a small employer group. Such characteristics can include family composition, group size, industry. (7-1-98)

05. Risk Load. Risk Load means the percentage above the applicable base premium rate that is

charged by a small employer carrier to the rates of the small employer group, to reflect the risk characteristics of the small employer group. (1-25-95)

005. -- 010. (RESERVED)

011. ASSESSMENTS.

Annual Assessment To Fund Losses. The Board shall, prior to March 1st of each year determine and file with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer Reinsurance Program in the previous calendar year. This interim assessment shall be based on the assessment formula set forth in Section 41-4711(12)(c), Idaho Code. Initial or interim assessments paid will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known. (3-15-02)

012. -- 014. (RESERVED)

015. APPLICABILITY.

- 01. Applicability.** This rule applies to any health benefit plan provided on a group basis, that: (4-5-00)
- Code;
- a.** Meets one (1) or more of the conditions set forth in Sections 41-4704(1) through 41-4704(4), Idaho Code; (1-25-95)
 - b.** Offers coverage to two (2) or more eligible employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state; and, (3-15-02)
 - c.** Is in effect on or after the effective date of the Act. (1-25-95)
- 02. Group Policy or Trust Arrangement.** The provisions of the Act and this rule shall apply to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group unless such health benefit plan(s) are subject to Title 41, Chapter 52, Idaho Code. (4-5-00)
- 03. Group Policy or Trust Arrangement.** The provisions of the Act and this rule shall apply to a health benefit plan provided to a small employer or to the eligible employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group. (1-25-95)
- 04. Subsequent Employment of More Than Fifty Eligible Employees.** If a small employer is issued a health benefit plan under the terms of the Act, the provisions of the Act and this rule shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than fifty (50) eligible employees. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than fifty (50) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protections provided under the Act and this rule shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan. (7-1-98)
- 05. Employer Subsequently Becomes a Small Employer.** If a health benefit plan is issued to an employer that is not a small employer as defined in the Act, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of the Act shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of the Act solely because the carrier continues to provide coverage under the health benefit plan to the employer. (1-25-95)
- 06. Time Period for Notification of Options to Employer.** A carrier providing coverage to an employer described in Subsection 015.05 shall, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notify the employer of the options and protections available to the employer under

the Act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier. (3-15-02)

07. Employees in More Than One State. If a small employer has employees in more than one (1) state, the provisions of the Act and this rule shall apply to a health benefit plan issued to the small employer if: (1-25-95)

a. The majority of eligible employees of such small employer are employed in this state; or (1-25-95)

b. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state. (1-25-95)

08. Laws of This State or Another State. In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in Subsection 015.07, the provisions of the paragraph shall be applied as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect. (3-15-02)

09. Health Benefit Plan Subject to The Act and This Rule. If a health benefit plan is subject to the Act and this rule, the provisions of the Act and this rule shall apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state. (1-25-95)

10. When Is a Small Employer Carrier Not Subject to the Act and This Rule. A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this rule solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state. (1-25-95)

016. -- 020. (RESERVED)

021. ESTABLISHMENT OF CLASSES OF BUSINESS.

01. Supporting Documentation for Establishment of Classes of Business. A small employer carrier that establishes more than one class of business pursuant to the provisions of Section 41-4705, Idaho Code, shall maintain on file for inspection by the Director the following information with respect to each class of business so established: (1-25-95)

a. A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business; (1-25-95)

b. A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in Section 41-4705, Idaho Code; and, (1-25-95)

c. A statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans. (1-25-95)

02. Group Size Will Not Be Acceptable as Eligibility Criterion for Class of Business. A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business. (1-25-95)

022. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless: (1-25-95)

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (1-25-95)

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (1-25-95)

c. The transaction otherwise meets the requirements of Section 028. (1-25-95)

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this rule. The Director shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable after the filing. (1-25-95)

03. Filing Requirements. The filing required under Subsection 028.02 shall: (1-25-95)

a. Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (1-25-95)

b. Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business (pursuant to Subsection 028.08 or will incorporate them into an existing class of business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health benefit plans will be incorporated; (1-25-95)

c. Describe whether the health benefit plans being assumed are currently available for purchase by small employers; (1-25-95)

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; (1-25-95)

e. Describe the potential effect of the assumption, if any on the premiums for the health benefit plans to be assumed; (1-25-95)

f. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and (1-25-95)

g. Include any other information required by the Director. (1-25-95)

04. Requirements for Informational Filings in Each State in Which There are Small Employer Health Benefit Plans. A small employer carrier required to make a filing under Subsection 028.02 shall also make an informational filing with the Insurance Supervisory Official of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under Subsection 028.02 and shall include at least the information specified in Subsection 028.03 for the small employer health benefit plans in that state. (1-25-95)

05. Other Provisions and Conditions to be Considered in the Transfer and Assumption of the Entire Insurance Obligation. A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions: (1-25-95)

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in Subsection 028.03 for the health benefit

plans covering small employers in this state. (1-25-95)

b. If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in Section 41-4706(1)(a), Idaho Code, the assuming carrier shall make a filing with the Director pursuant to Section 41-4706(3), Idaho Code, seeking suspension of the application of Section 41-4706(1)(a), Idaho Code. (1-25-95)

c. An assuming carrier seeking suspension of the application of Section 41-4706(1)(a), Idaho Code, shall not complete the assumption of health benefit plans covering small employers in this state unless the Director grants the suspension requested pursuant to Subsection 028.05.b. (1-25-95)

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-4706(1)(a), Idaho Code, shall, with respect to an assumed class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business). (1-25-95)

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business within Idaho which includes such health benefit plan. (1-25-95)

07. Requirements for Ceding Less Than an Entire Class of Business. A small employer carrier may cede less than an entire class of business to an assuming carrier if: (1-25-95)

a. One (1) or more small employers in the class have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or (1-25-95)

b. After a written request from the transferring carrier, the Director determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business. (1-25-95)

08. Separate Class of Business. Except as provided in Subsection 028.09, a small employer carrier that assumes one (1) or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business. (1-25-95)

09. Provisions for Exceeding the Maximum Number of Classes of Business. A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in Section 41-4705(2), Idaho Code, (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions: (1-25-95)

a. Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans. (1-25-95)

b. The transfers authorized in Subsection 028.09.a. shall occur with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business. (1-25-95)

c. A small employer carrier making a transfer pursuant to Subsection 028.09.a. may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred. (1-25-95)

d. The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to Subsection 028.09.a. Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption. (1-25-95)

e. During the fifteen-month (15) period provided in this Subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection shall not be considered a violation of the first sentence of Section 41-4706(2), Idaho Code. (1-25-95)

10. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. (1-25-95)

11. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period. (1-25-95)

12. Additional Information. Nothing in Section 028 or in the Act is intended to: (1-25-95)

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (1-25-95)

b. Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or (1-25-95)

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. (1-25-95)

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Separate Rate Manual for Each Class of Business. A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (1-25-95)

02. Requirements for Adjustments to Rating Method. A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this subsection. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this rule. (1-25-95)

03. Information Required for Review of Modification of Rating Method. A carrier may modify the rating method for a class of business only with prior approval of the Director. A carrier requesting to change the rating method for a class of business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (1-25-95)

- a. The reasons the change in rating method is being requested; (1-25-95)
 - b. A complete description of each of the proposed modifications to the rating method; (1-25-95)
 - c. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan); (1-25-95)
 - d. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (1-25-95)
 - e. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Section 41-4706, Idaho Code. (1-25-95)
- 04. Change in Rating Method.** For the purpose of Section 036 a change in rating method shall mean: (1-25-95)
- a. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business (a small employer should not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-98)
 - b. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business; (1-25-95)
 - c. A change in the method of allocating expenses among health benefit plans in a class of business; or (1-25-95)
 - d. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). (1-25-95)
 - e. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (1-25-95)
- 05. Rate Manual to Specify Case Characteristics and Rate Factors to Be Applied.** The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business. (1-25-95)
- 06. Case Characteristics Shall Be Applied in a Uniform Manner.** A small employer carrier shall use the same case characteristics as defined in Section 41-4706(1)(h), Idaho Code, in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer. (3-15-02)
- 07. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate and any Difference in New Business Rate.** The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference. (1-25-95)
- 08. Differences in Premium Rates Must Reflect Reasonable and Objective Differences.** Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective

differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. (1-25-95)

09. Premium Rates to be Developed in Two Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-4706, Idaho Code, to reflect the risk characteristics of the group. (1-25-95)

10. Exception to Application Fee, Underwriter Fee, or Other Fees. Except as provided in Subsection 036.11, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (3-15-02)

11. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to every health benefit plan in a class of business. All such fees are premium and shall be included in determining compliance with the Act and these rules. (1-25-95)

12. Uniform Allocation of Administration Expenses. The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed. (4-5-00)

13. Rate Manual to be Maintained for a Period of Six Years. Each rate manual developed pursuant to Subsection 036.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (3-15-02)

14. Rate Manual and Practices Must Comply with Guidelines Issued by Director. The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Director. (1-25-95)

15. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-4706(1)(c), Idaho Code, and shall be applied as follows: (1-25-95)

a. A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (1-25-95)

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 41-4706(1)(c)(i), Idaho Code. (3-15-02)

c. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of Sections 41-4706(1)(c)(i), Idaho Code. (3-15-02)

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period. (1-25-95)

e. A small employer carrier shall keep on file for a period of at least six (6) years the calculations used

to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (1-25-95)

16. Change in Premium Rate. Except as provided in Subsections 036.17 and 036.18, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following: (3-15-02)

a. The base premium rate for the small employer, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by; (1-25-95)

b. One (1) plus the sum of: (1-25-95)

i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)

17. Rating Restrictions on Plans Where Carrier Is No Longer Enrolling New Business. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by Subsections 036.17.a. and 036.17.b. below. (3-15-02)

a. One (1) plus the lesser of: (1-25-95)

i. The change in the base rate; or (1-25-95)

ii. The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers. (1-25-95)

b. One (1) plus the sum of: (1-25-95)

i. The risk load applicable to the small employer during the previous rating period; and (1-25-95)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (1-25-95)

18. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.16 and 036.17, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-4706(1)(b), Idaho Code. (3-15-02)

19. Waiver Request for a Taft-Hartley Trust. A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file a written request with the Director for the waiver of application of the provisions of Section 41-4706(1), Idaho Code, with respect to such trust. (1-25-95)

20. Provisions for Which Trust Is Seeking Waiver. A request made under Subsection 036.19 shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would: (3-15-02)

a. Adversely affect the participants and beneficiaries of the trust; and (1-25-95)

b. Require modifications to one (1) or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained. (1-25-95)

21. Waiver Shall Not Apply to Individual or Associate Member. A waiver granted under this provision shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (1-25-95)

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE ENTIRE GROUPS.

01. Offer of Coverage. A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in Subsection 046.02, the small employer carrier shall provide the same health benefit plan to each such employee and dependent. (1-25-95)

02. Choice of Health Benefit Plans. A small employer carrier may offer the employees of a small employer the option of choosing among one (1) or more health benefit plans, provided that each eligible employee may choose any of the offered plans. Except as provided in Section 41-4708(3), Idaho Code, (with respect to exclusions for pre-existing conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents. (1-25-95)

03. Participation Requirement. The small employer carrier may impose reasonable minimum participation requirements for issuance of coverage to small employers, subject to prior approval from the Director. (1-25-95)

04. Employer Census and Supporting Documentation. A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to prepare or provide an employer census of dependents and eligible employees as defined in Sections 41-4703(11) and 41-4703(13), Idaho Code. The small employer carrier shall require the small employer to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form) or a certification of information by a Small Employer as to the current census information. (3-15-02)

05. Waiver for Documentation of Coverage. A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form, and shall include a statement informing the eligible employee of the special enrollment rights provided within the Section 41-4703(17)(d) and (e), Idaho Code, and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six (6) years. (3-15-02)

06. Refusal to Provide Information. A small employer carrier shall not issue coverage to a small employer that refuses to provide the list required under Subsection 046.04 or a waiver required under Subsection 046.05, except for the following: (3-15-02)

a. The excluded individual has coverage under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan. (1-25-95)

07. Small Employer Carrier Shall Not Issue Coverage. A small employer carrier shall not issue coverage to a small employer if the carrier, or an agent for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to a health status related factor of the individual. (3-15-02)

08. Agent Notification to Small Employer Carrier. An agent shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics. (1-25-95)

09. New Entrants. New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such group based upon the provisions of Section 41-4708, Idaho Code. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by

the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer to all new enrollees under the Employee Benefit Plan. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to Subsection 046.02, the new entrant shall be offered the same choice of health benefit plans as the other members of the group. (3-15-02)

10. Small Employer Carrier Shall Not Apply Waiting Period or Similar Limitation. A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing medical conditions consistent with Section 41-4708(3), Idaho Code). (3-15-02)

11. No Restrictions or Limitations on Coverage Related to Risk Characteristics. New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-4708(3), Idaho Code. (1-25-95)

12. Risk Load. A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-4706, Idaho Code. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group. (1-25-95)

13. Rescission Employer Misstatements. When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option against the coverage of an entire small employer (including employees and dependents) and shall be limited to circumstances under which the application misstatements have been made by the small employer. When rescission action is taken, per Section 41-4707(1)(b), Idaho Code, premiums must be refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (4-5-00)

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

Restrictions on offering small group health insurance. A carrier that has been prohibited from writing coverage for small employers in this state pursuant to Section 41-4707(2), Idaho Code, may not resume offering health benefit plans to small employers in this state until the carrier has made a petition to the Director to be reinstated as a small employer carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (1-25-95)

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-4703(17), 41-4703(23), and 41-4708(3)(c), Idaho Code, a small employer carrier shall interpret the Act no less favorably to an insured individual than the following: (3-15-02)

a. A health benefit plan, certificate, or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement. (3-15-02)

02. Source of Previous or Existing Coverage. A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier. The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage. (1-25-95)

03. Certification of Creditable Coverage. Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection 060.03. (3-15-02)

a. A small employer carrier shall be deemed to have satisfied the certification requirements of Subsection 060.03 if another person provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period has been provided by another person. (3-15-02)

b. To the extent coverage under a health benefit plan consists of group coverage the plan shall be deemed to have satisfied the certification requirements of Subsection 060.03 if the small employer carrier offering the coverage is required to provide the certificates of creditable coverage to individuals pursuant to an agreement between the plan and the carrier. (3-15-02)

c. A small employer carrier is not required to provide information regarding health benefit plan coverage provided to an individual by another person. (3-15-02)

i. If an individual's coverage under a policy ceases before the individual's coverage under the group health plan ceases, the entity that issued the policy shall provide sufficient information to the small employer carrier, or to another person designated by the carrier, to enable the carrier, or other person, to provide a certificate that reflects the period of coverage under the policy, after the individual's coverage under the group health plan ceases. (3-15-02)

ii. The provision of the information pursuant to Subsection 060.03.c.i. to the new carrier shall satisfy the entity's obligation to provide an automatic certificate pursuant to Subsection 060.03. (3-15-02)

iii. The carrier providing the information about creditable coverage pursuant to Subsection 060.03 shall cooperate with other carriers in responding to any request for additional information. (3-15-02)

iv. If the individual's coverage under a group health plan ceases, the carrier that issued the group policy shall provide an automatic certificate of coverage. (3-15-02)

d. A small employer carrier shall provide a certification of creditable coverage, without charge, to participants or dependents who are or were covered under the group health benefit plan. (3-15-02)

e. A small employer carrier shall provide a certificate at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date the individual's coverage ceased under the plan. (3-15-02)

i. Each small employer carrier shall establish a procedure for individuals to request and receive certificates under Subsection 060.03. Upon a receipt of the request, the small employer carrier shall provide the certificate by the earliest date that the carrier, acting in a reasonable and prompt fashion, can provide the certificate. (3-15-02)

f. A certificate provided pursuant to Subsection 060.03 must include the following: (3-15-02)

i. The date the certificate was issued; (3-15-02)

ii. The name of the group health plan that provided the coverage described in the certificate; (3-15-02)

iii. The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan; (3-15-02)

iv. The name, address, and telephone number of the plan administrator required to provide the certificate; (3-15-02)

v. The telephone number to call for further information regarding the certificate; and (3-15-02)

- vi. Either, a statement that the individual has at least twelve (12) months of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or (3-15-02)
- vii. The date any waiting period or affiliation period, if applicable, began and the date creditable coverage began; and (3-15-02)
- viii. The date creditable coverage ended, unless the certificate indicates that the creditable coverage is continuing as of the date of the certificate. (3-15-02)
- g. Small employer carriers may provide a certificate required to be provided pursuant to Subsection 060.03 by first-class mail, at the participant's last known address. (3-15-02)
- h. The model for the certification of coverage may be found on the Department of Insurance Internet website is <http://www.doi.idaho.gov> and select the link "Health Information." (3-15-02)

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.

Except as permitted in Section 41-4708(3), Idaho Code, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent for specific diseases, medical conditions, including but not limited to pregnancy, or services otherwise covered by the plan. (3-15-02)

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Small Employer Carrier Shall Actively Market. A small employer carrier shall actively market each of its health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the basic, standard, or catastrophic health benefit plans unless the carrier has good cause and has received the prior approval of the Director. (7-1-98)

02. Marketing Basic, Standard, or Catastrophic Plans. In marketing the basic, standard, or catastrophic health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic, standard, or catastrophic health benefit plans. (7-1-98)

03. Offer Must Be in Writing. A small employer carrier shall offer all small group health benefit plans to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. The offer shall be in writing and shall include at least the following information: (4-5-00)

a. A general description of the benefits and base rates contained in all actively marketed, including but not limited to the mandated, health benefit plans; and (3-15-02)

b. Information describing how the small employer may enroll in the plans. The offer may be provided directly to the small employer or delivered through a producer. (1-25-95)

04. Timeliness of Price Quote. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten (10) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote. (1-25-95)

05. Toll-Free Telephone Service. A small employer carrier shall establish and maintain a toll-free

telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (1-25-95)

06. Restrictions as to Contribution to Association. The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of Section 41-4708, Idaho Code. (3-15-02)

07. No Requirement to Qualify for Other Insurance Product. A small employer carrier may not require, as a condition to the offer of sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service. (1-25-95)

08. Plans Subject to Requirement of the Act and This Rule. Carriers offering group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this rule. (4-5-00)

09. Annual Filing Requirement. A small employer carrier shall file annually the following information with the Director related to health benefit plans issued by the small employer carrier to small employers in this state on forms prescribed by the Director: (1-25-95)

a. The number of small employers that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (1-25-95)

b. The number of small employers that were covered under the basic, standard, or catastrophic health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (7-1-98)

c. The number of small employer health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; (1-25-95)

d. The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year; (1-25-95)

e. The number of small employer health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (1-25-95)

f. The number of health benefit plans that were issued to residents that were uninsured for at least sixty-three (63) days prior to issue. (7-1-98)

10. Total Number of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss or stop loss plans. (3-15-02)

11. Filing Date. The information described in Subsections 075.09 and 075.10 shall be filed no later than March 1, each year. (3-15-02)

12. Specific Data. For purposes of this section, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity and stop loss coverages. (1-25-95)

076. -- 080. (RESERVED)

081. STATUS OF CARRIERS AS SMALL EMPLOYER CARRIERS.

01. Market Status. Each carrier providing health benefit plans in this state shall make a filing to the Director if it intends to continue or discontinue to operate as a small employer carrier in this state under the terms of this rule. (1-25-95)

02. Restrictions as to the Offering of Insurance. Subject to Subsection 081.03, a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to Subsection 081.01 indicates that the carrier intends to operate as a small employer carrier in this state. (1-25-95)

03. Specific Compliance Requirements. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions: (1-25-95)

a. The carrier complies with the requirements of the Act (other than Sections 41-4709, 41-4710, and 41-4711, Idaho Code) with respect to each of the health benefit plans previously issued to small employers by the carrier. (1-25-95)

b. The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier. The provisions of the Act (other than Sections 41-4709, 41-4710, and 41-4711, Idaho Code) and this rule shall apply to the coverage issued to such new entrants. (1-25-95)

c. The carrier complies with the requirements of Section 067 of this rule as they apply to small employers whose coverage has been terminated by the carrier and to small employers whose coverage has been limited or restricted by the carrier. (4-5-00)

04. Not Eligible for Reinsurance Program. A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Section 41-4711, Idaho Code. (1-25-95)

05. Precluded from Operating in Idaho. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in Subsections 081.03.a. through 081.03.c.) for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Director may reduce the period provided for in the previous sentence if the Director finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state. (1-25-95)

082. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 13**

**18.04.13 – RULES GOVERNING SMALL EMPLOYER HEALTH INSURANCE
AVAILABILITY ACT PLAN DESIGN**

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapters 2 and 47, Idaho Code. (1-25-95)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.04.13, “Rules Governing Small Employer Health Insurance Availability Act Plan Design.” (1-25-95)

02. Scope. The Act and this rule are intended to promote broader spreading of risk in the small employer marketplace. The Act and rule are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this rule. (1-25-95)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-15-02)

004. DEFINITIONS.

As used in this rule: (1-25-95)

01. Benefit Percentage. Benefit percentage is the percentage of the cost of a health care service paid by the insurer under a health insurance plan as defined in the schedule of benefits. (1-25-95)

02. Calendar Year. Calendar year is a period of one (1) year which starts on January 1st and ends on December 31st. (1-25-95)

03. Coinsurance. Coinsurance is a percentage of the cost of a health care service, paid by the patient under a health insurance plan, as defined in the schedule of benefits. (1-25-95)

04. Copayment. Copayment is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a copayment will be required are specified in the schedule of benefits. (1-25-95)

05. Expense. Expense means the expense incurred for a covered service or supply. A physician or other licensed practitioner has to order or prescribe the service or supply. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge: (1-25-95)

a. For a service or supply which is not medically necessary; or (1-25-95)

b. Which is in excess of reasonable and customary charge for a service or supply. (1-25-95)

06. Medical Emergency. Medical emergency means a severe onset of a condition which: (1-25-95)

a. Results in symptoms which occur suddenly and unexpectedly; and (1-25-95)

b. Requires immediate physician’s care to prevent death or serious impairment of the insured person’s health; or (1-25-95)

c. Poses a serious threat to the patient or to others. (1-25-95)

07. Medically Necessary Service or Supply. Medically necessary service or supply means one which is ordered by a physician and which the small employer carrier or a qualified party or entity selected by us determines is: (1-25-95)

a. Provided for the diagnosis or direct treatment of an injury or sickness; (1-25-95)

b. Appropriate and consistent with the symptoms and findings of diagnosis and treatment of the insured persons injury or sickness; (1-25-95)

c. Is not considered experimental or investigative; (1-25-95)

d. Provided in accord with generally accepted medical practice; (1-25-95)

e. The most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, in-patient vs. out-patient care, electric vs. manual wheelchair, surgical vs. medical or other types of care.) The fact that the insured person’s physician prescribes services or supplies does not automatically mean such service or supply are medically necessary and covered by the policy. (1-25-95)

08. Out-of-Pocket Expense. Out-of-pocket expense is the medical expense that an insured must pay, which includes deductibles and coinsurance but not copayment, as defined in the schedule of benefits. (1-25-95)

09. Physician. Physician means any of the following licensees duly licensed by the state of Idaho to practice in any of the following categories of health care professions: (1-25-95)

a. Chiropractor; (1-25-95)

b. Dentist; (1-25-95)

c. Optometrist; (1-25-95)

d. Pharmacist; (1-25-95)

e. Physician and surgeon, of either medicine and surgery or of osteopathic medicine and surgery; and (1-25-95)

f. Podiatrist; and (1-25-95)

g. Any other licensed practitioner who is acting within the scope of that license and who performs a service which is payable under the policy when performed by any of the above health care practitioners. A physician does not include a person who lives with the insured or is part of insureds family (spouse, child, brother, sister, or parent of insured or insureds spouse). (1-25-95)

10. Pre-Existing Condition. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual’s coverage due to a pre-existing condition. (1-25-95)

a. A health benefit plan shall not define a pre-existing condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. (7-1-98)

b. Genetic information shall not be considered as a condition described in Subsection 010.10 in the absence of a diagnosis of the condition related to such information. (7-1-98)

c. A health benefit plan shall waive any time period applicable to a pre-existing condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. This provision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan. (7-1-98)

d. A health benefit plan may exclude coverage for late enrollees for the greater of twelve (12) months or for a twelve (12) months pre-existing condition exclusion; provided that if both a period of exclusion from coverage and a pre-existing condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve (12) months from the date the individual enrolls for coverage under the health benefit plan. (1-25-95)

11. Restricted Network Provision. Restricted network provision means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Chapter 34, Title 41, Idaho Code, and Chapter 39, Title 41, Idaho Code, to provide health care services to covered individuals. (7-1-98)

005. -- 014. (RESERVED)

015. COORDINATION OF BENEFITS.

Coordination of benefits shall be utilized on the small employer basic, standard, and catastrophic plans based upon IDAPA 18.04.15, "Coordination of Benefits." (3-15-02)

016. LIMITATIONS AND EXCLUSIONS.

A health benefit plan shall not limit or exclude coverage by type of illness, accident, treatment, or medical condition, except as follows: (4-11-19)

01. Services Not Medically Necessary. Excluded. Any service not medically necessary or appropriate unless specifically included within the coverage provisions. (1-25-95)

02. No Coverage. Custodial, convalescent or intermediate level care or rest cures. (1-25-95)

03. Experimental or Investigational. Services which are experimental or investigational. (1-25-95)

04. Workers' Compensation, Medicare, CHAMPUS. Services eligible for coverage by Workers' Compensation, Medicare or CHAMPUS. (1-25-95)

05. No Charges. Services for which no charges are made or for which no charges would be made in the absence of insurance or for which the insured has no legal obligation to pay. (1-25-95)

06. No Medical Diagnosis. Services for weight control, nutrition, and smoking cessation, including self-help and training programs as well as prescription drugs, used in conjunction with such programs and services. (7-1-98)

07. Cosmetic Surgery. Cosmetic surgery and services, except for treatment or surgery for congenital anomaly. Mastectomy reconstruction is covered as described in the Women's Health and Cancer Rights Act. (3-15-02)

08. Artificial Insemination, Infertility, Sexual Dysfunction. Artificial insemination and infertility treatment. Treatment of sexual dysfunction not related to organic disease. (1-25-95)

09. Induced Infertility. Services for reversal of elective, surgically or pharmaceutically induced infertility. (1-25-95)

- 10. Vision.** Vision therapy, tests, glasses, contact lenses and other vision aids. Radial keratotomy, myopic keratomileusis and any surgery involving corneal tissue to alter or correct myopia, hyperopia or stigmatic error. Vision tests and glasses will be covered for children under the age of twelve (12), except in catastrophic health benefit plans. (7-1-98)
- 11. Limitation Foot Care.** For treatment of weak, strained, or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal, or treatment of corns, calluses, or nails other than corrective surgery, or for metabolic or peripheral vascular disease. (7-1-98)
- 12. Manipulative Therapy and Related Treatment.** Manipulative therapy and related treatment, including heat treatments and ultrasound, of the musculoskeletal structure for other than fractures and dislocations of the extremities will be subject to one thousand dollars (\$1,000) per year limit, subject to the policy deductible, co-insurance, or co-payment. (4-5-00)
- 13. Dental, Orthodontic Services.** (7-1-98)
- a.** For Basic and Standard plans: Dental and orthodontic services, except those needed for treatment of a medical condition or injury or as specifically allowed in the policy for children under the age of twelve (12). (7-1-98)
- b.** For Catastrophic plans: Dental care or treatment, except for injury sustained while insured under this policy, or as a result of nondental disease covered by the policy. (7-1-98)
- 14. Hearing Tests.** Hearing tests without illness being suspect. (1-25-95)
- 15. Hearing Aids.** Hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device. (4-11-19)
- 16. Speech Tests.** Speech tests and therapy except as specifically allowed in the policy for children under the age of twelve (12). (1-25-95)
- 17. Private Room Accommodation Charges.** Private room accommodation charges in excess of the institution's most common semi-private room charge except when prescribed as medically necessary. (1-25-95)
- 18. Services Performed by a Member of the Insured's Family.** Services performed by a member of the insured's family or of the insured's spouse's family. Family includes parents or grandparents of the insured or spouse and any descendants of such parents or grandparents. (1-25-95)
- 19. No Coverage Prior to Effective Date of Coverage.** Care incurred before the effective date of the person's coverage. (1-25-95)
- 20. Covered Injury or Disease.** Immunizations and medical exams and tests of any kind not related to treatment of covered injury or disease, except as specifically stated in the policy. (1-25-95)
- 21. Act of War or Armed Conflict.** Injury or sickness caused by war or armed international conflict. (1-25-95)
- 22. Operation and Treatment, Sexual Change.** Sex change operations and treatment in connection with transsexualism. (1-25-95)
- 23. Counseling.** Marriage and family and child counseling except as specifically allowed in the policy. (1-25-95)
- 24. Acupuncture.** (7-1-98)

- a. For Basic and Standard plans: Acupuncture except when used as anesthesia during a covered surgical procedure. (7-1-98)
 - b. For Catastrophic plans: Acupuncture. (7-1-98)
 - 25. **Private Duty Nursing.** Private duty nursing except as specifically allowed in the policy. (1-25-95)
 - 26. **Employer Maintained Medical or Dental Care.** Services received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group. (1-25-95)
 - 27. **Termination.** Services incurred after the date of termination of a covered person’s coverage except as allowed by the extension of benefits provision of the policy, if any. (7-1-98)
 - 28. **Personal Convenience Items.** Expenses for personal hygiene and convenience items such as air conditioners, humidifiers, and physical fitness equipment. (1-25-95)
 - 29. **Failure to Keep a Scheduled Visit.** Charges for failure to keep a scheduled visit, charges for completion of any form, and charges for medical information. (1-25-95)
 - 30. **Screening Examinations.** Charges for screening examinations except as otherwise provided in the policy. (1-25-95)
 - 31. **No Allowance.** Charges for wigs or cranial prostheses, hair analysis, hair loss and baldness. (1-25-95)
 - 32. **Preexisting Conditions.** Pre-existing conditions, except as provided specifically in the policy. (1-25-95)
017. -- 999. (RESERVED)

**APPENDIX A
 MANAGED CARE STANDARD BENEFIT PLAN**

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	\$100,000
Preventive Services (Benefit Area A)	
Copayment:	
-Adults	\$15
-Children	\$0
Benefit Percentage	\$100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	\$500
Vision Annual Benefit Sub-cap*	\$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	\$15
Benefit Percentage	100%

SCHEDULE OF BENEFITS	
All Benefit Areas	
Coinsurance Percentage	0%
Other Maternity (Benefit Area B2)	
Copayment (per admission)	\$500
Benefit Percentage	80%
Coinsurance Percentage	20%
Inpatient Services (Benefit Area C)	
Copayment (per admission)	\$500
Benefit Percentage	80%
Coinsurance Percentage	20%
Outpatient Services (Benefit Area D)	
Copayment	
1. Emergency Room+	\$100
2. Outpatient Surgery	\$200
3. Office Visits and Other Outpatient Services	\$20
+\$100 network provider; \$200 non-designated provider	
Transportation & Medical Equipment (Benefit Area E)	
Emergency Ambulance Service	
Annual Benefit Maximum*	\$750
Copayment	\$100
Benefit Percentage	0%
Coinsurance Percentage	0%
Durable Medical Equipment	
Annual Benefit Maximum*	\$15,000
Copayment	\$0
Benefit Percentage	80%
Coinsurance Percentage	20%
Psychiatric and Substance Abuse (Benefit Area F)	
Annual Benefit Maximum (Inpatient and Outpatient)*	\$5,000
Outpatient	
Sub-cap	1,500
Copayment	\$0
Benefit percentage	50%
Coinsurance percentage	50%

SCHEDULE OF BENEFITS	
All Benefit Areas	
Inpatient	
Copayment	500
Benefit percentage	80%
Coinsurance percentage	20%
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000

(Applicable to Benefit Areas “B2,” “C,” “D,” “E” and “F”)

*Maximum benefit payable during any twelve (12) month period.

** One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

**APPENDIX B
 STANDARD BENEFIT PLAN**

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	\$100,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	\$15
-Children	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	\$500
Vision Annual Benefit Sub-cap*	\$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	\$15

SCHEDULE OF BENEFITS	
All Benefit Areas	
Benefit Percentage	100%
Coinsurance Percentage	0%
BENEFIT AREAS B2, C, D, E, F	
Calendar Year Deductible	
Individual	\$500
Family	\$1,000
Benefit Percentage	80%
Coinsurance Percentage	20%
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000
Emergency Ambulance Service Annual Benefit Maximum*	\$750
Durable Medical Equipment Annual Benefit Maximum*	\$15,000
Psychiatric and Substance Abuse Services	
Annual Benefit Maximum*	\$5,000
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

**APPENDIX C
 MANAGED CARE BASIC BENEFIT PLAN**

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	\$25,000
Preventive Services (Benefit Area A)	

SCHEDULE OF BENEFITS	
All Benefit Areas	
Copayment	
-Adults	\$15
-Children	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	\$500
Vision Annual Benefit Sub-cap*	\$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	\$15
Benefit Percentage	100%
Coinsurance Percentage.	0%
Other Maternity (Benefit Area B2)	
Copayment (per admission)	\$1,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Inpatient Services (Benefit Area C)	
Copayment (per admission)	\$1,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Outpatient Services (Benefit Area D)	
Copayment	
1. Emergency Room+	\$100
2. Outpatient Surgery	\$400
3. Office Visits and Other Outpatient Services	\$30
+\$100 network provider; \$200 non-designated provider	
Transportation & Medical Equipment (Benefit Area E)	
Emergency Ambulance Service	
Annual Benefit Maximum*	\$750
Copayment	\$200
Benefit Percentage	100%
Coinsurance Percentage	0%
Durable Medical Equipment	
Annual Benefit Maximum*	\$15,000
Copayment	\$0

SCHEDULE OF BENEFITS	
All Benefit Areas	
Benefit Percentage	50%
Coinsurance Percentage	50%
Psychiatric and Substance Abuse (Benefit Area F)	
Annual Benefit Maximum (Outpatient)*	\$1,500
Copayment	\$0
Benefit percentage	50%
Coinsurance percentage	50%
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000

(Applicable to Benefit Areas “B2,” “C,” “D,” “E”)

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX D
BASIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	\$25,000
Preventive Services (Benefit Area A)	
Copayment	
-Adults	\$15
-Children under Age 12	\$0
Benefit Percentage	100%
Coinsurance Percentage	0%
Annual Benefit Maximum*	\$500

SCHEDULE OF BENEFITS	
All Benefit Areas	
Vision Annual Benefit Sub-cap*	\$75
Primary Maternity Services (Benefit Area B1)	
Initial Visit Copayment	\$15
Benefit Percentage	100%
Coinsurance Percentage	0%
Benefit Areas B2, C, D, E, F	
Calendar Year Deductible	
Individual	\$1,000
Family	\$2,000
Benefit Percentage.	50%
Coinsurance Percentage	50%
Out-of-Pocket Expense Limit	
Individual	\$5,000
Family	\$10,000
Emergency Ambulance Service	
Annual Benefit Maximum*	\$750
Durable Medical Equipment	
Annual Benefit Maximum*	\$15,000
Psychiatric and Substance Abuse Services Annual Benefit Maximum*	
Outpatient	\$2,500
Pharmacy Benefits (Benefit Area G)	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**

*Maximum benefit payable during any twelve (12) month period.

**One hundred percent (100%) of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, one hundred percent (100%) of the cost of the brand name drug after the copayment is payable.

APPENDIX E
MANAGED CARE CATASTROPHIC BENEFIT PLAN

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Benefit Maximum	\$200,000
Calendar Year Out-of-Pocket Limits	
For Copayments and Coinsurance:	
-per person	\$12,000
- per family	\$24,000
The per person Benefit maximum applies when family coverage is purchased.	
Copayments - Only as stated for specific Benefit Areas	
Coinsurance - Only as stated for specific Benefit Areas	
Benefit Area A	
Preventive Services	
Copayment	
- Adults	\$20
- Children	\$0
Annual Benefit Maximum	\$250
Benefit Area B	
Maternity	
Outpatient Maternity Copayment per Visit	\$20
Outpatient Maternity Out-Of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)	\$240
Inpatient Maternity Copayment per Day per pregnancy	\$500
Inpatient Maternity Out-Of-Pocket Expense Limit (per pregnancy) (fully paid thereafter)	\$1,000
Benefit Area C	
General Inpatient Services	
Copayment per Day (not to exceed 5 days per admission)	\$500
Out-of-Pocket Expense Limit per Admission	\$2,500
Benefit Area D	
General Outpatient Services	
Copayment per Office Visit	\$20
Copayment for Laboratory and Radiology (X-ray)	\$0
Benefit Area E	
Transportation and Medical Equipment	

SCHEDULE OF BENEFITS	
All Benefit Areas	
Ambulance	
-Coinsurance per Trip	50%
-Annual Benefit Sub-maximum	\$750
Durable Medical Equipment	
-Coinsurance	50%
-Annual Benefit Sub-maximum	\$10,000
Benefit Area F	
Psychiatric and Substance Abuse	
Outpatient Services	
(not including drugs are covered under Area G)	
-Copayment per Visit	\$50
-Annual number of Covered Visits	10
Inpatient Services (including drugs)	
-Copayment per Day	\$400
-Annual maximum number of Covered Days	10
Benefit Area G	
Drugs and Pharmaceuticals	
Coinsurance for each prescription, for up to a 30-day supply (formularies permitted - subjects unlisted drugs to managed care plan approval)	50%

**APPENDIX F
CATASTROPHIC BENEFIT PLAN**

SCHEDULE OF BENEFITS	
All Benefit Areas	
Calendar Year Individual Benefit Maximum	\$200,000
Calendar Year Deductible	
Individual	\$2,000 or \$5,000
Family	\$4,000 or \$10,000
Benefit Percentage	50%
Coinsurance Percentage	50%
Calendar Year Out-of-Pocket Expense Limit	

SCHEDULE OF BENEFITS	
All Benefit Areas	
Individual	\$10,000 for \$2,000 deductible \$13,000 for \$5,000 deductible
Family	\$20,000 for \$4,000 deductible \$26,000 for \$10,000 deductible

Change to Higher Deductible - Charges previously applied to deductible amount for the same year are applied to the new deductible amount. New covered charges are applied to the new deductible amount. Change to lower deductible is not permitted. Charges applied to the deductible amount are not carried over to the next calendar year.

BENEFIT AREA A	
Preventive Services Annual Benefit Maximum*	\$500
BENEFIT AREAS B2, C, D, E, F	
Emergency Ambulance Service Annual Benefit Maximum*	\$750
Durable Medical Equipment Annual Benefit Maximum*	\$15,000
Psychiatric and Substance Abuse Services Annual Benefit Maximum*	\$5,000
BENEFIT AREA G	
Pharmacy Benefits	
Copayment per Prescription	\$10
Benefit Percentage	100%**
Coinsurance	0%**

* Maximum benefit payable during any twelve (12) month period.

** 100% of the cost of the generic substitute (when available) is paid. The insured must pay the difference between the cost of a brand name drug and the generic substitute if a brand name drug is selected when a generic is available. If a generic substitute is not available, 100% of the cost of the brand name drug after the copayment is payable.

**IDAPA 18
TITLE 04
CHAPTER 14**

**18.04.14 – RULE TO IMPLEMENT THE INDIVIDUAL HEALTH
INSURANCE AVAILABILITY ACT**

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapters 2, 52, and 55, Title 41, Idaho Code. (3-15-02)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.14, “Rule to Implement the Individual Health Insurance Availability Act.” (7-1-98)

02. Scope. The Act and this rule are intended to promote broader spreading of risk in the individual marketplace. The Act and rule are intended to regulate all health benefit plans sold to eligible individuals. Carriers that provide health benefit plans to eligible individuals are intended to be subject to all of the provisions of the Act and this rule. (7-1-98)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-15-02)

004. DEFINITIONS.

As used in this rule: (7-1-98)

01. Geographic Area. Geographic areas are limited to six (6) designated areas, with no area being smaller than a county. (7-1-98)

02. Risk Characteristic. Risk Characteristic means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or claims experience of an individual. Such characteristics can include family composition. (7-1-98)

03. Risk Load. Risk Load means the percentage above the applicable base premium rate that is charged by an individual carrier to the rates of the eligible individual, to reflect the risk characteristics of the eligible individual. (7-1-98)

04. Idaho Resident. Idaho resident means a person who is able to provide satisfactory proof of having resided in Idaho, as their place of domicile for a continuous six (6) month period, for purposes of being an eligible individual pursuant to Section 41-5203(10), Idaho Code. The six (6) month residency requirements would be waived for eligible individuals based on the Health Insurance Portability and Accountability Act of 1996. (3-15-02)

005. -- 010. (RESERVED)

011. ASSESSMENTS.

Annual Assessment To Fund Losses. The Board shall, prior to March 1st of each year, determine and file with the Director an estimate of the assessments needed to fund the losses incurred by the Idaho Small Employer and Individual Health Reinsurance Program. The March 1, 2001 assessment anticipated by Section 41-4711, Idaho Code, will consist of the amounts needed to cover the claims cost of the individual policies issued on or before June 30, 2000. This interim assessment shall be based on the assessment formula set forth in Section 41-4711(12)(c), Idaho

Code. Initial or interim assessments paid, on behalf of the Idaho Individual High Risk Reinsurance Pool, will be credited to each carrier's account when the amounts needed to fund losses and pay program expenses are known. (3-15-02)

012. -- 027. (RESERVED)

028. TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER.

01. Conditions for Transfer or Assumption of Entire Insurance Obligation. An individual carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an individual in this state unless: (7-1-98)

a. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the assuming carrier; (7-1-98)

b. The transaction received any necessary approval of the insurance supervisory official of the state of domicile of the ceding carrier; and, (7-1-98)

c. The transaction otherwise meets the requirements of Section 028. (7-1-98)

02. Time Frame for Filing Plan to Assume or Cede Entire Insurance Obligation. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more individual health benefit plans from another carrier shall make a filing for approval with the Director at least sixty (60) days prior to the date of the proposed assumption. The Director may approve the transaction if the Director finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the Act and this rule. The Director shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Director may approve the transaction as soon as the Director deems reasonable after the filing. (7-1-98)

03. Filing Requirements. The filing required under Subsection 028.02 shall: (7-1-98)

a. Describe the health benefit plan (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded; (7-1-98)

b. Describe whether the assuming carrier will maintain the assumed health benefit plans (pursuant to Subsection 028.08) or will incorporate them into existing business (pursuant to Subsection 028.09). If the assumed health benefit plans will be incorporated into existing business, the filing shall describe the business of the assuming carrier into which the health benefit plans will be incorporated; (7-1-98)

c. Describe whether the health benefit plans being assumed are currently available for purchase by eligible individuals; (7-1-98)

d. Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed; (7-1-98)

e. Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed; (7-1-98)

f. Describe any other potential material effects of the assumption on the coverage provided to the eligible individuals covered by the health benefit plans to be assumed; and (7-1-98)

g. Include any other information required by the Director. (7-1-98)

04. Requirements for Informational Filings in Each State in Which There are Individual Health Benefit Plans. An individual carrier required to make a filing under Subsection 028.02 shall also make an informational filing with the Insurance Supervisory Official of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with

the filing made under Subsection 028.02 and shall include at least the information specified in Subsection 028.03 for the individual health benefit plans in that state. (7-1-98)

05. Other Provisions and Conditions to be Considered in the Transfer and Assumption of the Entire Insurance Obligation. An individual carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering an eligible individual in this state unless it complies with the following provisions: (7-1-98)

a. The carrier has provided notice to the Director at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in Subsection 028.03 for the health benefit plans covering eligible individuals in this state. (7-1-98)

b. If the assumption of a health benefit plan would result in the assuming individual carrier being out of compliance with the limitations related to premium rates contained in Section 41-5206(1)(a), Idaho Code, the assuming carrier shall make a filing with the Director pursuant to Section 41-5206(2), Idaho Code, seeking suspension of the application of Section 41-5206(1)(a), Idaho Code. (7-1-98)

c. An assuming carrier seeking suspension of the application of Section 41-5206(1)(a), Idaho Code, shall not complete the assumption of health benefit plans covering eligible individuals in this state unless the Director grants the suspension requested pursuant to Subsection 028.05.b. (7-1-98)

d. Unless a different period is approved by the Director, a suspension of the application of Section 41-5206(1)(a), Idaho Code, shall, with respect to assumed one (1) or more health benefit plans, be for no more than fifteen (15) months and, with respect to each individual, shall last only until the anniversary date of such individual's coverage (except that the period with respect to an individual may be extended beyond such individual first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the health benefit plan). (7-1-98)

06. Exceptions to Ceding or Assumption of Business. Except as provided in Subsection 028.02, an individual carrier shall not cede or assume the entire insurance obligation or risk for an individual health benefit plan unless the transaction includes the ceding to the assuming carrier of all business within Idaho which includes such health benefit plan. (7-1-98)

07. Requirements for Ceding Less Than Entire Business. An Individual carrier may cede less than an entire health benefit plan to an assuming carrier if: (7-1-98)

a. One (1) or more eligible individuals in the health benefit plan have exercised their right under contract to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan with the exception of those health benefit plans for which an eligible individual has rejected the proposed cession; or (7-1-98)

b. After a written request from the transferring carrier, the Director determines that the transfer of less than all health benefit plans is in the best interests of the eligible individuals insured. (7-1-98)

08. Separate Health Benefit Plans. Except as provided in Subsection 028.09, an individual carrier that assumes one (1) or more health benefit plans from another carrier may maintain such health benefit plans as a separate health benefit plan. (7-1-98)

09. Restrictions to Apply Eligibility Requirements by Assuming Carrier. An assuming carrier may not apply eligibility requirements, with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to an eligible individual covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption. (7-1-98)

10. Request for Extension of the Transition Period. The Director may approve a longer period of transition upon application of an individual carrier. The application shall be made within sixty (60) days after the date of assumption of the health benefit plan and shall clearly state the justification for a longer transition period. (7-1-98)

- 11. Additional Information.** Nothing in Section 028 or in the Act is intended to: (7-1-98)
- a.** Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Section 41-511, Idaho Code, of the ceding or assuming carrier related to the transaction; (7-1-98)
 - b.** Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or (7-1-98)
 - c.** Reduce or diminish the protections related to an assumption reinsurance transaction provided in Section 41-511, Idaho Code, or otherwise provided by law. (7-1-98)

029. -- 035. (RESERVED)

036. RESTRICTIONS RELATING TO PREMIUM RATES.

01. Rate Manual. An individual carrier shall develop a rate manual for all individual business. Base premium rates and new business premium rates charged to eligible individuals by the individual carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by an individual carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. (7-1-98)

02. Requirements for Adjustments to Rating Method. An individual carrier shall not modify the rating method used in the rate manual for its individual business until the change has been approved as provided in this paragraph. The Director may approve a change to a rating method if the Director finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this rule. (7-1-98)

03. Information Required for Review of Modification of Rating Method. A carrier may modify the rating method for its individual business only with prior approval of the Director. A carrier requesting to change the rating method for its individual business shall make a filing with the Director at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information: (7-1-98)

- a.** The reasons the change in rating method is being requested; (7-1-98)
- b.** A complete description of each of the proposed modifications to the rating method; (7-1-98)
- c.** A description of how the change in rating method would affect the premium rates currently charged to eligible individuals in the health benefit plan, including an estimate from a qualified actuary of the number of individuals (and a description of the types of individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all individuals in a health benefit plan); (7-1-98)
- d.** A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and (7-1-98)
- e.** A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for eligible individuals that would be in violation of Section 41-5206, Idaho Code. (7-1-98)

04. Change in Rating Method. For the purpose of Section 036 a change in rating method shall mean: (7-1-98)

- a.** A change in the number of case characteristics used by an individual carrier to determine premium rates for health benefit plans in its individual business (an individual carrier shall not use case characteristics other than age, individual tobacco use, geography or gender without prior approval of the Director); (7-1-98)
- b.** A change in the method of allocating expenses among health benefit plans; or (7-1-98)
- c.** A change in a rating factor with respect to any case characteristic if the change would produce a

change in premium for any individual that exceeds ten percent (10%). (7-1-98)

d. For the purpose of Subsection 036.04, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If an individual carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test. (7-1-98)

05. Rate Manual to Specify Case Characteristics and Rate Factors to be Applied. The rate manual developed pursuant to Subsection 036.01 shall specify the case characteristics and rate factors to be applied by the individual carrier in establishing premium rates for the health benefit plans. (7-1-98)

06. Case Characteristics Other Than Age, Individual Tobacco Use, Geography and Gender - Must Have Prior Approval of Director. An individual carrier may not use case characteristics other than those specified in Section 41-5206(1)(f), Idaho Code, without the prior approval of the Director. An individual carrier seeking such an approval shall make a filing with the Director for a change in rating method under Subsection 036.02. (3-15-02)

07. Case Characteristics Shall be Applied in a Uniform Manner. An individual carrier shall use the same case characteristics in establishing premium rates for each health benefit plan and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of an eligible individual. (7-1-98)

08. Rate Manual Must Clearly Illustrate Relationship Among Base Premium Rate and Any Difference in New Business Rate. The rate manual developed pursuant to Subsection 036.01 shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference. (7-1-98)

09. Differences in Premium Rates Must Reflect Reasonable and Objective Differences. Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the eligible individual or groups that choose or are expected to choose a particular health benefit plan. An individual carrier shall apply case characteristics and rate factors within its health benefit plans in a manner that assures that premium differences among health benefit plans for identical individuals vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the individuals that choose or are expected to choose a particular health benefit plan. (3-15-02)

10. Premium Rates to be Developed in Two Step Process. The rate manual developed pursuant to Subsection 036.01 shall provide for premium rates to be developed in a two (2) step process. In the first step, a base premium rate shall be developed for the eligible individual without regard to any risk characteristics. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Section 41-5206, Idaho Code, to reflect the risk characteristics of the individual. (7-1-98)

11. Exception to Application Fee, Underwriter Fee or Other Fees. Except as provided in Subsection 036.12, a premium charged to an individual for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. (7-1-98)

12. Uniform Application of Fees. A carrier may charge a separate fee with respect to a health benefit plan provided the fee is applied in a uniform manner to all health benefit plans. All such fees are premium and shall be included in determining compliance with the Act and this rule. (7-1-98)

13. Uniform Allocation of Administration Expenses. An individual carrier shall allocate administrative expenses to the basic, standard, and catastrophic health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans. The rate manual developed pursuant to Subsection 036.01 shall describe the method of allocating administrative expenses to the health benefit plans for which the manual was developed. (7-1-98)

14. Rate Manual to be Maintained for a Period of Six Years. Each rate manual developed pursuant to Subsection 036.01 shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual. (7-1-98)

15. Rate Manual and Practices Must Comply With Guidelines Issued by Director. The rate manual and rating practices of an individual carrier shall comply with any guidelines issued by the Director. (7-1-98)

16. Application of Restrictions Related to Changes in Premium Rates. The restrictions related to changes in premium rates are set forth in Section 41-5206(1)(b), Idaho Code, and shall be applied as follows: (7-1-98)

a. An individual carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates. (7-1-98)

b. If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of Sections 41-5206(1)(b)(i) and 41-5206(1)(d)(i), Idaho Code. (4-5-00)

c. If for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the individual carrier is no longer enrolling new eligible individuals for the purposes of Sections 41-5206(1)(b)(i), Idaho Code. (3-15-02)

d. If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan by more than twenty percent (20%), the carrier shall make a filing with the Director containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period. (7-1-98)

e. An individual carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period. (7-1-98)

17. Change in Premium Rate. Except as provided in Subsection 036.18, a change in premium rate for an eligible individual shall produce a revised premium rate that is no more than the following: (4-5-00)

a. The base premium rate for the eligible individual, given its present composition, (as shown in the rate manual as revised for the rating period), multiplied by: (7-1-98)

b. One (1) plus the sum of: (7-1-98)

i. The risk load applicable to the eligible individual during the previous rating period; and (7-1-98)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-98)

18. Rating Restrictions on Plans Where Carrier Is No Longer Enrolling New Business. In the case of a health benefit plan into which an Individual carrier is no longer enrolling new Individuals, a change in premium rate for an Individual shall produce a revised premium rate that is no more than the base premium rate for the Individual (given its present composition and as shown in the rate manual in effect for the Individual at the beginning of the previous rating period), multiplied by Subsection 036.18.a. and 036.18.b.; (4-5-00)

a. One (1) plus the lesser of: (7-1-98)

i. The change in the base rate; or (7-1-98)

ii. The percentage change in the new business premium for the most similar health benefit plan into which the Individual carrier is enrolling new Individuals. (7-1-98)

b. One (1) plus the sum of: (7-1-98)

i. The risk load applicable to the Individual during the previous rating period; and (7-1-98)

ii. Fifteen percent (15%) (prorated for periods of less than one (1) year). (7-1-98)

19. Limitations on Revised Premium Rate. Notwithstanding the provisions of Subsections 036.17 and 036.18, a change in premium rate for an Individual shall not produce a revised premium rate that would exceed the limitations on rates provided in Section 41-5206, Idaho Code. (7-1-98)

037. -- 045. (RESERVED)

046. REQUIREMENT TO INSURE INDIVIDUALS.

01. Offer of Coverage. An individual carrier that offers coverage to an individual shall offer to provide coverage to each eligible individual and to each eligible dependent of an eligible individual. (7-1-98)

02. No Restrictions or Limitations on Coverage Related to Risk Characteristics. Individuals shall be accepted for coverage by the individual carrier without any restrictions or limitations on coverage related to the risk characteristics of the Individual or their dependents, except that a carrier may exclude or limit coverage for pre-existing medical conditions, consistent with the provisions provided in Section 41-5208(3), Idaho Code. (7-1-98)

03. Risk Load. An individual carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of Section 41-5206, Idaho Code. The risk load shall be the same risk load charged to the Individual immediately prior to acceptance of the new entrant into the health benefit plan. (7-1-98)

04. Rescission. When material application misstatements are found, rescission action by the carrier shall be taken at the carrier's option. When rescission action is taken, premiums must be refunded less any claims which had been paid prior to the date the rescission was initiated. At the carrier's option, the carrier shall seek to recover any amounts of claims paid in excess of premiums paid. The applicable contract or coverage shall be considered null and void. (7-1-98)

05. Coverage Rescinded for Fraud or Misrepresentation. Any individual whose coverage is subsequently rescinded for fraud or misrepresentation shall not be deemed to be an "eligible individual" for a period of twelve (12) months from the effective date of the termination of the individual coverage and shall not be deemed to have "qualifying previous coverage" under Chapter 22, 47, 52, or 55, Title 41, Idaho Code; provided such limitations cannot be in conflict with the Health Insurance Portability and Accountability Act of 1996. (3-15-02)

06. Certification of Creditable Coverage. (3-15-02)

a. Individual carriers shall provide written certification of creditable coverage to individuals in accordance with Subsection 046.06.b. (3-15-02)

b. The certification of creditable coverage shall be provided: (3-15-02)

i. At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision; (3-15-02)

ii. In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and (3-15-02)

iii. Such certification shall automatically be provided by the individual carrier or at the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage described in Subsections 046.06.b.i. and 046.06.b.ii., whichever is later. (3-15-02)

- c. The certificate of creditable coverage shall contain: (3-15-02)
 - i. Written certification of the period of creditable coverage of the individual under the health benefit plan; and (3-15-02)
 - ii. The waiting period, if any, and if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan. (3-15-02)

047. -- 054. (RESERVED)

055. APPLICATION TO REENTER STATE.

01. Restrictions on Offering Individual Health Insurance. An individual carrier that has been prohibited from writing coverage for individuals in this state pursuant to Section 41-5207(2), Idaho Code, may not resume offering health benefit plans to individuals in this state until the carrier has made a petition to the Director to be reinstated as an individual carrier and the petition has been approved by the Director. In reviewing a petition, the Director may ask for such information and assurances as the Director finds reasonable and appropriate. (7-1-98)

02. Restrictions Based on Geographic Service Area. In the case of an individual carrier doing business in only one established geographic service area of the state, if the individual carrier elects to non renew a health benefit plan under Section 41-5207(3), Idaho Code, the individual carrier shall be prohibited from offering health benefit plans to individuals in that service area for a period of five (5) years. (4-5-00)

056. -- 059. (RESERVED)

060. QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES.

01. Previous Coverage or Existing Coverage. In determining whether a health benefit plan or other health benefit arrangement (whether public or private) shall be considered qualifying previous coverage or qualifying existing coverage for the purposes of Sections 41-5203(20), and 41-5208(3), Idaho Code, an individual carrier shall interpret the Act no less favorably to an insured individual than the following: (3-15-02)

a. An individual carrier shall ascertain the source of previous or existing coverage of each eligible individual and each dependent of an eligible individual at the time such individual or dependent initially enrolls into the health benefit plan provided by the individual carrier. (3-15-02)

061. -- 066. (RESERVED)

067. RESTRICTIVE RIDERS.

Except as permitted in Section 41-5208(3), Idaho Code, an individual carrier shall not modify or restrict any health benefit plan with respect to any eligible individual or dependent of an eligible individual, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such individual or dependent for specific diseases, medical conditions or services otherwise covered by the plan. (3-15-02)

068. -- 074. (RESERVED)

075. RULES RELATED TO FAIR MARKETING.

01. Individual Carrier Shall Actively Market. An individual carrier shall actively market each of its health benefit plans to individuals in this state. An individual carrier may not suspend the marketing or issuance of the basic, standard, or catastrophic health benefit plans unless the carrier has good cause and has received the prior approval of the Director. (7-1-98)

02. Marketing Basic, Standard, and Catastrophic Plans. In marketing the basic, standard, and catastrophic health benefit plans to individuals, an individual carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to individuals. Any producer authorized by an

individual carrier to market health benefit plans to Individuals in the state shall also be authorized to market the basic, standard, and catastrophic health benefit plans. (4-5-00)

03. Offer Must be in Writing. An individual carrier shall offer at least the basic, standard, and catastrophic health benefit plans to any individual that applies for or makes an inquiry regarding health insurance coverage from the individual carrier. The offer shall be in writing and shall include at least the following information: (4-5-00)

- a. A general description of the benefits contained in the basic, standard, and catastrophic health benefit plans and any other health benefit plan being offered to the individual; and (7-1-98)
- b. Information describing how the individual may enroll in the plans. (7-1-98)
- c. The offer may be provided directly to the individual or delivered through a producer. (7-1-98)

04. Timeliness of Price Quote. An individual carrier shall provide a price quote to an individual (directly or through an authorized producer) within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. An individual carrier shall notify an individual (directly or through an authorized producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the individual carrier to provide the quote. (7-1-98)

05. Restrictions as to Application Process. An individual carrier may not apply more stringent or detailed requirements related to the application process for the basic, standard, and catastrophic health benefit plans than are applied for other health benefit plans offered by the carrier. (7-1-98)

06. Denial of Coverage. If an individual carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and shall be maintained in the individual carrier's office. This written denial shall state with specificity the risk characteristic(s) of the individual that made it ineligible for the health benefit plan it requested (for example, health status). The denial shall be accompanied by a written explanation of the availability of the basic, standard, and catastrophic health benefit plans from the individual carrier. The explanation shall include at least the following: (7-1-98)

- a. A general description of the benefits contained in each such plan; (7-1-98)
- b. A price quote for each such plan; and (7-1-98)
- c. Information describing how the individual may enroll in such plans. (7-1-98)
- d. The written information described in this paragraph may be provided within the time periods provided in Subsection 075.04 directly to the individual or delivered through an authorized producer. (7-1-98)

07. Premium Rate Charged. The price quote required under Subsection 075.06.b. shall be for the lowest premium rate charged under the rating system for a health benefit plan for which the individual is eligible. (3-15-02)

08. Toll-Free Telephone Service. An individual carrier shall establish and maintain a toll-free telephone service to provide information to individuals regarding the availability of individual health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage. (7-1-98)

09. No Requirement to Qualify for Other Insurance Product. An individual carrier may not require, as a condition to the offer of sale of a health benefit plan to an individual, that the individual purchase or qualify for any other insurance product or service. (7-1-98)

10. Plans Subject to Requirement of the Act and This Rule. Carriers offering individual health

benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Act and this rule. Carriers shall elicit the following information from applicants for such plans at the time of application. (7-1-98)

11. Annual Filing Requirement. An individual carrier shall file annually the following information with the Director related to health benefit plans issued by the individual carrier to individuals in this state on forms prescribed by the Director: (7-1-98)

a. The number of individuals that were covered under health benefit plans in the previous calendar year (separated as to newly issued plans and renewals); (7-1-98)

b. The number of individuals that were covered under the basic, standard, and catastrophic health benefit plan in the previous calendar year (separated as to newly issued plans and renewals). (7-1-98)

c. The number of individual health benefit plans in force in each county (or by five (5) digit zip code) of the state as of December 31 of the previous calendar year; (7-1-98)

d. The number of individual health benefit plans that were voluntarily not renewed by Individuals in the previous calendar year; (7-1-98)

e. The number of individual health benefit plans that were terminated or non renewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and (7-1-98)

f. The number of health benefit plans that were issued to residents that were uninsured for at least the sixty-three (63) days prior to issue. (7-1-98)

12. Total Number of Residents. All carriers shall file annually with the Director, on forms prescribed by the Director, the total number of residents, including spouses and dependents, covered during the previous calendar year under all health benefit plans issued in this state. This includes residents covered under reinsurance by way of excess loss and stop loss plans. (3-15-02)

13. Filing Date. The information described in Subsections 075.12 and 075.13 shall be filed no later than March 15, each year. (7-1-98)

14. Specific Data. For purposes of Subsection 073.14, health benefit plan information shall include policies or certificates of insurance for specific disease, hospital confinement indemnity, reinsurance by way of excess loss, and stop loss coverages. (3-15-02)

076. -- 080. (RESERVED)

081. STATUS OF CARRIERS AS INDIVIDUAL CARRIERS.

01. Market Status. Each carrier providing health benefit plans in this state shall make a filing to the Director if it intends to continue or discontinue to operate as an individual carrier in this state under the terms of this rule. (7-1-98)

02. Restrictions as to the Offering of Insurance. Subject to Subsection 081.03, a carrier shall not offer health benefit plans to individuals, or continue to provide coverage under health benefit plans previously issued to individuals in this state, unless the filing provided pursuant to Subsection 081.01 indicates that the carrier intends to operate as a individual carrier in this state. (7-1-98)

03. Specific Compliance Requirements. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a individual carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to individuals in this state only if the carrier complies with the following provisions: (7-1-98)

a. The carrier complies with the requirements of Title 41, Chapters 21, 42, and 52, Idaho Code, (other

than Sections 41-5209, 41-5210, and 41-4711, Idaho Code) with respect to each of the health benefit plans previously issued to individuals by the carrier. (3-15-02)

b. The carrier provides coverage to each new dependent to a health benefit plan previously issued to an individual by the carrier. The provisions of the Act (other than Sections 41-5209, 41-5210, and 41-4711, Idaho Code) and this rule shall apply to the coverage issued to such new dependents. (7-1-98)

c. The carrier complies with the requirements of Section 067 of this rule as they apply to individuals whose coverage has been terminated by the carrier and to individuals whose coverage has been limited or restricted by the carrier. (7-1-98)

04. Not Eligible for Reinsurance Program. A carrier that continues to provide coverage pursuant to this subsection shall not be eligible to participate in the reinsurance program established under Sections 41-4711 and 41-5505, Idaho Code. (3-15-02)

05. Precluded From Operating in Idaho. If the filing made pursuant Subsection 081.01 indicates that a carrier does not intend to operate as a individual carrier in this state, the carrier shall be precluded from operating as an individual carrier in this state (except as provided for in Subsections 081.03.a. through 081.03.c.) for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Director may reduce the period provided for in the previous sentence if the Director finds that permitting the carrier to operate as an individual carrier would be in the best interests of the individuals in the state. (3-15-02)

082. -- 999. (RESERVED)

**IDAPA 18
TITLE 04
CHAPTER 15**

18.04.15 – COORDINATION OF BENEFITS

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapters 2, 21, 22 and 34, Title 41, Idaho Code. (7-1-98)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.04.15, “Coordination of Benefits.” (7-1-98)

02. Scope. The purpose of this rule is to permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law; establish a uniform order of benefit determination under which plans pay claims; provide authority for the orderly transfer of necessary information and funds between plans; reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to these rules, do not pay their benefits first; reduce claims payment delays; and require that COB provisions be consistent with this rule; and provide greater efficiency in the processing of claims when a person is covered under more than one (1) plan. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost at this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.01.01, “Idaho Rules of Administrative Procedure of the Attorney General,” Sections 000 through 099. (3-30-07)

004. INCORPORATION BY REFERENCE.

This rule incorporates by reference the full text of the National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions and the National Association of Insurance Commissioners Consumer Explanatory Booklet, published as part of the 2013 model rules of the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800 Kansas City, MO 64108-2662, and available on the Idaho Department of Insurance website. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. The department’s mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)

04. Web Site Address. The department’s website is <https://doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provision of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

As used in this rule, these words and terms have the following meanings, unless the context clearly indicates otherwise: (7-1-98)

01. Allowable Expense. “Allowable expense” 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. If a plan 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 in accordance with 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. An expense that a provider by law or in accordance with contractual agreement is prohibited from charging a covered person is not an allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. (3-30-07)

a. The following are examples of expenses or services that are not an allowable expense: (3-30-07)

i. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient’s stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans provides coverage for private hospital rooms) is not an allowable expense. (3-30-07)

ii. If a person is covered by two (2) 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 methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense. (3-30-07)

iii. If a person is covered by two (2) 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. (7-1-98)

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits. (3-30-07)

b. The definition of the “allowable expense” may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expenses 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” shall include similar expenses to which COB applies. (3-30-07)

c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid. (7-1-98)

d. The amount of the reduction may be excluded from allowable expense when a covered person’s benefits are reduced under a primary plan: (7-1-98)

i. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services: or (3-30-07)

ii. Because the covered person has a lower benefit because the covered person did not use a preferred provider. (3-30-07)

02. Birthday. “Birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born. (3-30-07)

03. Claim. “Claim” means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (7-1-98)

- a.** Services (including supplies); (7-1-98)
- b.** Payment for all or a portion of the expenses incurred; (7-1-98)
- c.** A combination of Paragraphs 010.03.a. and 010.03.b. of this chapter; or (3-30-07)
- d.** An indemnification. (7-1-98)

04. Closed Panel Plan. “Closed panel plan” means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or 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. (3-30-07)

05. Consolidated Omnibus Budget Reconciliation Act of 1985. “Consolidated Omnibus Budget Reconciliation Act of 1985” or “COBRA” means coverage provided under a right of continuation pursuant to federal law. (3-30-07)

06. Coordination of Benefits. “Coordination of benefits” (COB) means a provision establishing an order in which 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. (3-30-07)

07. Custodial Parent. “Custodial parent” means the parent awarded custody by a court decree. 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. (3-30-07)

08. Group-Type Contract. Group-type contract means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer. (3-30-07)

09. High-deductible Health Plan. “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. (6-30-19)T

10. Hospital Indemnity Benefits. “Hospital indemnity benefits” means the benefits not related to expenses incurred. The term 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. (7-1-98)

11. Plan. “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. If a plan coordinates benefits, its contract shall 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 Subsection 010.11. The definition of “plan” in the model COB provision in the National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions is an example. The National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions can be found on the Department of Insurance Internet website, Consumer Services link. (3-30-07)

- a.** Plan includes: (3-30-07)

- i. Group and nongroup insurance contracts and subscriber contracts; (3-30-07)
- ii. Uninsured group or group-type coverage arrangements; (3-30-07)
- iii. Group and nongroup coverage through closed panel plans; (3-30-07)
- iv. Group-type contracts; (3-30-07)
- v. The medical care components of long-term care contracts, such as skilled nursing care; (3-30-07)
- vi. Medicare or other governmental benefits, except as provided in Subparagraph 010.11.b.ix. of this chapter. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. (3-30-07)
- vii. The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts. No plan is required to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it shall do so in compliance with the provisions of this chapter. (3-30-07)
- viii. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental or vision care. (6-30-19)T
- b.** Plan shall not include: (7-1-98)
 - i. Hospital indemnity coverage or other fixed indemnity coverage; (3-30-07)
 - ii. School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a “to and from school” basis; (3-30-07)
 - iii. Specified disease or specified accident coverage; (3-30-07)
 - iv. Accident only coverage; (3-30-07)
 - v. Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, 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; (3-30-07)
 - vi. Limited benefit health coverage as defined in IDAPA 18.04.08, “Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule,” Sections 012 and 029; (3-30-07)
 - vii. Medicare supplement policies; (3-30-07)
 - viii. A state plan under Medicaid; or (3-30-07)
 - ix. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. (7-1-98)
- 12. Policyholder.** “Policyholder” means the primary insured named in a non-group insurance policy. (3-30-07)
- 13. Primary Plan.** “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 is a primary plan if; (3-30-07)
 - a.** The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; or (3-30-07)

b. All plans that cover the person use the order of benefit determination required by this rule, and under those rules the plan determines its benefits first. (3-30-07)

14. Secondary Plan. “Secondary plan” means a plan that is not a primary plan. (3-30-07)

011. -- 020. (RESERVED)

021. COB CONTRACT PROVISION.

01. Coordination of Benefits, “Model Coordination of Benefits Contract Provisions.” The National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections 021.02 through 021.04, of this chapter, and the provisions of Section 022 of this chapter. The National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions is incorporated by reference and can be found on the Department of Insurance website. (3-30-07)

02. Coordination of Benefits Attachment “National Association of Insurance Commissioners Consumer Explanatory Booklet.” The National Association of Insurance Commissioners Consumer Explanatory Booklet 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 set forth in the contract. Its purpose is to explain the process by which two (2) or more plans will pay for or provide benefits. The National Association of Insurance Commissioners Consumer Explanatory Booklet is incorporated by reference and can be found on the Department of Insurance website. (3-30-07)

03. Application of Requirements. The COB provision contained in the the National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions and the plain language explanation in the National Association of Insurance Commissioners Consumer Explanatory Booklet do not have to use the specific words and format shown in the National Association of Insurance Commissioners Model Coordination of Benefits Contract Provisions or the National Association of Insurance Commissioners Consumer Explanatory Booklet. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted. (3-30-07)

04. Limits on COB Provisions. A COB provision may not be used that permits a plan to reduce benefits on the basis that: (7-1-98)

a. Another plan exists and the covered person did not enroll in that plan; (7-1-98)

b. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or (7-1-98)

c. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. (7-1-98)

05. “Always Excess” or “Always Secondary.” No plan may contain a provision that its benefits are “always excess” or “always secondary” except in accordance with this rule. (3-30-07)

06. Closed Panel Provider. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of Section 023 of this chapter to determine the amount it should pay for the benefit. (3-30-07)

07. Plan Requirements. 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

under Subsection 010.11 of this rule. (3-30-07)

022. RULES FOR COORDINATION OF BENEFITS.

01. Order of Benefit Payments. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: (7-1-98)

a. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist. (3-30-07)

b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. (3-30-07)

c. When multiple contracts providing coordinated coverage are treated as a single plan under this rule, Section 022 of this chapter 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 (1) carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this rule. (3-30-07)

d. If a person is covered by more than one (1) secondary plan, the order of benefit determination requirements of this rule decide the order in which secondary plan benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the requirements of this rule, has its benefits determined before those of that secondary plan. (3-30-07)

02. Consistent Order of Benefit Provisions. Except as provided in Paragraph 022.02.a. of this chapter, a plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of Subsection 022.02 of this chapter, state that the complying plan is primary. (3-30-07)

a. 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 shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. (7-1-98)

b. A plan may take into consideration the benefits paid or provided by another plan only when, under the requirements of this rule, it is secondary to that other plan. (3-30-07)

03. Order of Benefit Determination. Each plan determines its order of benefits using the first of the following rules that applies. (3-30-07)

a. Non-dependent or dependent. 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. However, if the person is a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing rules, Medicare is: (3-30-07)

i. Secondary to the plan covering the person as a dependent; and (7-1-98)

ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee), 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. (3-30-07)

b. Dependent Child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows: (3-30-07)

- i. For a dependent child whose parents are married or are living together, whether or not they have ever been married: (3-30-07)
- (1) The plan of the parent whose birthday falls earlier in the calendar year is primary plan; or (3-30-07)
 - (2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. (3-30-07)
- ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: (3-30-07)
- (1) 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 shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provisions; (3-30-07)
 - (2) 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 022.03.b.i. of this chapter shall determine the order of benefits; (3-30-07)
 - (3) If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph 022.03.b.i. of this chapter shall determine the order of benefits, or (3-30-07)
 - (4) 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 are as follows: (3-30-07)
 - (a) The plan covering the custodial parent; (3-30-07)
 - (b) The plan covering the custodial parent's spouse; (3-30-07)
 - (c) The plan covering the noncustodial parent; and then (3-30-07)
 - (d) The plan covering the noncustodial parent's spouse. (3-30-07)
 - (5) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable under Subparagraph 022.03.b.i. or 022.03.b.ii. of this chapter as if those individuals were parents of the child. (3-30-07)
 - (6) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the provisions of Paragraph 022.02.e. apply. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph 022.02.b.i. to the dependent child's parent(s) and the dependent's spouse. (6-30-19)T
- c. 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 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. 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 is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Paragraph 022.03.a. of this chapter. (3-30-07)
- d. Continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state 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 pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. 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 is ignored. This provision does not apply if the rule in Paragraph 022.03.a. of this chapter can determine the order of benefits. (3-30-07)

e. Longer/shorter length of coverage. 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 a shorter period of time is the secondary plan. (3-30-07)

i. To determine the length of time a person has been covered under a plan, two (2) successive plans shall be treated as one (1) if the covered person was eligible under the second plan within twenty-four (24) hours after the coverage under the first plan ended. (3-30-07)

ii. The start of a new plan does not include: (7-1-98)

(1) A change in the amount or scope of a plan's benefits; (3-30-07)

(2) A change in the entity that pays, provides or administers the plan's benefits; or (7-1-98)

(3) A change from one type of plan to another such as from a single employer plan to a multiple employer plan. (3-30-07)

iii. 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 shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. (7-1-98)

f. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans. (3-30-07)

023. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the 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 do not exceed one hundred percent (100%) of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other benefit care coverage. (6-30-19)T

024. NOTICE TO COVERED PERSONS.

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan." (6-30-19)T

025. MISCELLANEOUS PROVISIONS.

01. Benefits in the Form of Services. 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 shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services. (7-1-98)

02. Complying Plan Versus Noncomplying Plan. A plan with order of benefit determination rules that comply with this rule (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 rule (noncomplying plan) on the following basis: (7-1-98)

- a.** If the complying plan is the primary plan, it shall pay or provide its benefits first; (7-1-98)
- b.** If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and (3-30-07)
- c.** If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as the actual benefits of the noncomplying plan, it shall adjust payments accordingly. (7-1-98)
- i.** 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 noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference. (3-30-07)
- ii.** In no event shall 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 services. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation. (7-1-98)
- 03. COB Versus Subrogation.** COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. (3-30-07)
- 04. Timely Payment of Benefits.** If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary. (7-1-98)
- 026. -- 999. (RESERVED)**

**IDAPA 18
TITLE 05
CHAPTER 01**

18.05.01 – TITLE INSURANCE DEFINITION OF TRACT INDEXES AND ABSTRACT RECORDS

000. LEGAL AUTHORITY.

This Rule is promulgated pursuant to the general rule making authority in Section 41-211, Idaho Code, to aid in the effectuation of Section 41-2702, Idaho Code. (4-2-08)

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.05.01, “Title Insurance Definition of Tract Indexes and Abstract Records.” (4-2-08)

02. Application of Rule. The provisions of this rule apply to all title insurers and title insurance agents. This rule does not limit the Director’s authority to determine that other title insurance trade practices constitute violations of Section 41-2702, Idaho Code. (4-2-08)

03. Purpose. The purpose of this Rule is to define and clarify the meaning of “a complete set of tract indexes or abstract records” as used in Section 41-2702, Idaho Code. (4-2-08)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (4-2-08)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General - General Provisions.” (4-2-08)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (4-2-08)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-2-08)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-2-08)

03. Street Address. 700 West State Street, 3rd Floor, Boise, ID 83720-0043. (4-2-08)

04. Web Site Address. The department’s website at <http://www.doi.idaho.gov/>. (4-2-08)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-2-08)

007. -- 010. (RESERVED)

011. TRACT INDEXES OR ABSTRACT RECORDS.

For clarification and guidance, the following is considered to be the correct definition or meaning of “a complete set of tract indexes or abstract records” as used in Section 41-2702, Idaho Code: A set of indexes from which the record ownership and condition of title to all land within a particular county can be traced and ascertained. (4-2-08)

012. INDEX COMPONENTS.

01. Basic Component Parts. The basic component parts of such a set of indexes are: (7-1-93)

a. An index or indexes, to be complete from the inception of title from the United States of America, 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: (4-2-08)

i. All filed or recorded instruments legally affecting title to particularly described parcels of real property and which impart constructive notice under the recording laws; and (7-1-93)

ii. All judicial proceedings in the particular county legally 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 Subsection 012.01.b. of these rules. (7-1-93)

iii. No requirement is hereby made for taxes and assessments, water or otherwise, or for water and mineral rights, land use regulations, and zoning ordinances to be made a part of the plant records. (7-1-93)

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 legally affects or may legally 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, including guardianships, absentee, bankruptcies, receiverships, divorces and mental illness matters, if available, are posted, filed, entered or otherwise included in that part of the indexing system which designates the same. (7-1-93)

02. Index Maintenance. The indexes prescribed in Subsection 012.01 may be maintained in bound books, looseleaf 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. (7-1-93)

03. Subdivision or Refinement. The extent to which the prescribed indexes shall be subdivided or refined 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 requirements are entitled to consideration in such determination. (7-1-93)

04. Discarding or Destroying. Any requirement set forth in this rule to the contrary notwithstanding, it shall be permissible to discard and destroy prior index books, jackets, folders, cards, photoprints or files pertaining to recorded instruments affecting title to particularly described parcels of real property once the titles to such particularly described parcels have been searched, examined and a policy of owner's title insurance issued thereon. The discarding and destruction of prescribed index components herein provided for is applicable only when a permanent copy of the search notes, examiner's opinion and issued policy is retained in lieu of the discarded and destroyed index components. (7-1-93)

013. -- 999. (RESERVED)

**IDAPA 18
TITLE 05
CHAPTER 02**

18.05.02 – TITLE INSURANCE AND TITLE INSURANCE AGENTS AND ESCROW OFFICERS

000. LEGAL AUTHORITY.

These rules are promulgated pursuant to authority granted by Chapter 27 of Title 41, Idaho Code, Chapter 52 of Title 67, Idaho Code, and Section 41-211, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

The purpose of these rules is to adopt with reference to title insurance and title insurance agents and escrow officers rules governing rates charged for various services and insurability on certain matters; rules governing procedural methods as to the way the title insurers, title insurance agents and their officers are to perform certain actions and rules governing actions of title insurance agents and employees acting as escrow agents. The purpose is to further protect consumers of title insurance industry products by ensuring that consumers are not injured by delivery of certain funds or documents (for recordation or otherwise) from an escrow without prior receipt of "collected funds" by the escrow agent and to preserve the financial stability of title insurers and title insurance agents. (7-1-93)

002. -- 003. (RESERVED)

004. PREMIUM RATES AND THEIR APPLICATION.

01. Schedule of Premium Rates. Each title insurer shall file its schedule of premium rates (including both the taxable risk portion and the service portion) for title insurance charged the public for all policies, which premium rates shall commence with the lowest rate and shall advance by one thousand dollars (\$1,000) increments. The rate schedule shall include owner's, standard mortgagee and extended coverage mortgagee policies, and may include other rates. In addition, any charges made for special endorsements shall be listed and the type of policy to which applicable. Filed rates shall provide that where a preliminary report is issued, the order for the policy may be canceled prior to closing. The applicant may be required to pay a cancellation fee. The premium rates for policies shall only include title examination and issuance of title insurance which shall be deemed to include any preliminary report, commitment to insure, binder or similar report (herein collectively called preliminary report) and the policy subsequently issued thereon. If more than one (1) chain of title is involved, an additional charge shall be made for each additional chain. An additional chain is one involving property in a different block or section or under a different ownership within the last five (5) years. (3-28-18)

02. Issuing Binders, Commitments or Preliminary Reports. No title insurer or title insurance agent shall issue a title insurance binder, commitment or preliminary report without an order. (6-30-19)T

03. Amount of Owner's Policy. An owner's policy shall be issued for not less than (a) the amount of the current sales price of the land and any existing improvements appurtenant thereto, or (b) if no sale is being made, the amount equal to the value of the land and any existing improvements at the time of the issuance of the policy. If improvements are contemplated, the amount may include the cost of such improvements immediately contemplated to be erected thereon with a following pending improvement clause set forth in Schedule B of said policy and the full premium collected, which clause reduces the policy amount to the extent the improvements are not completed. The amount of policies covering leasehold estates for a term of fifty years or more shall be for the full value of the land and existing improvements, and for less than fifty years shall be for an amount at the option of the insured based on (i) the total amount of the rentals payable for the primary term but not less than five (5) years, or (ii) the full value of the land and existing improvements together with any improvements immediately contemplated to be erected thereon. The amount of policies insuring contract purchasers shall be for the full value of the principal payments. Insurance of lesser estates shall be written for the amount of the value of the estate at the time the policy is issued. (7-1-93)

04. Amount of Mortgagee Policies. A mortgagee's policy shall be for not less than the full principal debt of the loan insured and at insured's request may include up to twenty percent (20%) in excess of the principal debt to cover interest, foreclosure costs, etc. Where the land covered represents only part of the security for the loan, the policy shall be written for the amount of the unencumbered value of the land or the amount of the loan, whichever is the lesser. (7-1-93)

05. Simultaneous Issuance of Owner's and Mortgagee's Policy. When an owner's policy and a mortgage policy covering identical land are simultaneously issued, the owner's policy shall bear the regular owner's rate. Premium for the mortgagee policy simultaneously issued may be for an amount less than the full mortgagee rate for the amount of insurance not in excess of the owner's policy. (7-1-93)

06. Double Sale and Reissue. No order will be held open to cover a double sale and the premium will be charged and the policy issued on each sale, unless the conveyance on resale is recorded at the same time as the original transaction. A title insurer may file an owner's reissue rate of not less than fifty percent (50%) of the basic rate which shall be applicable to any policy ordered within two (2) years of the effective date of a prior owner's or purchaser's policy naming applicant as the insured provided that the following conditions are met: (7-1-93)

a. The prior policy or a copy thereof is presented to the issuing company and shall be retained in the issuing company's file, or in the absence thereof, reasonable proof of issuance is provided the issuing company. (7-1-93)

b. The reissue premium shall be based on the schedule of fees in effect at the time of reissue. (7-1-93)

c. Increased liability is to be computed in accordance with the basic schedule of fees in the applicable brackets. (7-1-93)

07. Amount on Litigation and Foreclosure Reports. Where a preliminary report is made for an owner's policy to be issued after a quiet title action or after a foreclosure of contracts of sale, deeds of trust or mortgages, the premium charge shall be that on an owner's policy and the policy will be issued following the successful completion of the litigation or the foreclosure. A cancellation fee may be charged if the action is unsuccessful. Each such preliminary report shall bear on its face as the limit of liability of the insurer, the value upon which the premium charge is based. (3-28-18)

005. PROCEDURAL RULES AND DEFINITIONS.

01. Definitions. All terms defined in chapters 1, 13, and 27, title 41 Idaho Code, which are used in this rule shall have the same meaning as used in those chapters. (6-30-19)T

a. Applicant. Applicant is a party to a real estate transaction who may be the buyer, seller and/or a proposed or named insured on a title commitment, policy, guaranty or other title insurance product. (6-30-19)T

b. Financial Interest. Financial Interest means any interest that entitles the holder in any manner to Two and one-half percent (2.5%) or more of the profits or net worth of the title entity in which the interest is held. (6-30-19)T

c. Policy. Any contract or form of title insurance which prior to its issuance has been filed with the Director of Insurance. (7-1-93)

d. Preliminary Report. A binder of insurance, a commitment to insure, a preliminary report of title, and litigation reports including quiet title action, foreclosure actions of contracts of sale, deeds of trust or mortgages where a policy of title insurance will be issued on the successful completion thereof. There is excluded herefrom miscellaneous reports which do not insure title, such as judgment reports, lot book reports or property search reports which are governed by Subsection 005.02. (7-1-93)

e. Producer of Title Business. "Producer of title business" includes any person engaged in this state in the trade, business, occupation or profession of: (6-30-19)T

i. Buying or selling interest in real property; or ()

ii. Making loans secured by interest in real property; and ()

iii. Shall include but not be limited to real estate agents, real estate brokers, mortgage brokers, lending

or financial institutions, builders, attorneys, developers, subdividers, auctioneers engaged in the sale of real property, consumers, and the employees, agents, representatives, or solicitors of any of the foregoing; and (6-30-19)T

iv. Shall include any legal entity whose ownership is, directly or indirectly, comprised fifty-one percent (51%) or more by entities or individuals described in Paragraph 010.03.c. of this rule. (6-30-19)T

f. **Title Examination.** A search and examination of the title and a determination of insurability of the title in accordance with sound title underwriting practices. Such examination of the public records shall be made only for the purpose of determining insurability of the described property and shall not be a report on the condition of the record. (7-1-93)

g. **Issuance of a Policy.** The preparation, execution and delivery of a title insurance policy which is hereby deemed to be only a contract of insurance up to the face amount of such policy and in no way shall create a tort liability as to the condition of the record insured from. The same shall include any necessary investigation just prior to actual issuance of a policy to determine if there has been proper execution, acknowledgement and delivery of any conveyances, mortgage papers, and other title instruments which may be necessary for the issuance of a policy. It shall also include determination of the status of taxes based on the latest available information and a final search of the title and that all necessary papers have been filed for record. Issuance of the policy shall not include services which are essentially escrow or closing services, such as receiving and disbursing money, prorating insurance and taxes, etc., for which an escrow fee shall be charged. The issuer of the policy may specify requirements necessary for the issuance of the title insurance, but it is the responsibility of the applicant for the insurance to meet such requirements and the title insurance agent shall not act for the applicant to satisfy the same. It is not the responsibility of the policy issuer to cure defects of title or remove liens or encumbrances, nor to perform services extraneous to the issuance of the policy. Title insurers and title insurance agents in the issuance of title insurance policies shall not do any acts which constitute the practice of law and the premium shall not include the cost of legal services to be performed for the benefit of anyone other than the company. A title insurance agent who is also a licensed lawyer rendering any legal services in the transaction insured must render a separate legal billing therefor and the escrow fees shall not include such legal services. (7-1-93)

h. **Tract Indexes and Abstract Records.** See IDAPA 18.05.01, Rules of the Department of Insurance. The tract indexes and abstract records shall be maintained and posted to current date and shall include adequate maps that will enable a person working the title plant to locate a tract of land which is the subject of the title examination. (7-1-93)

02. Miscellaneous Reports. Where an insurer or its agent issues judgment reports, lot book reports or property search reports, each such report shall specifically contain the following statement: "This report is based on a search of our tract indexes of the county records. This is not a title or ownership report and no examination of the title to the property described has been made. For this reason, no liability beyond the amount paid for this report is assumed hereunder, and the company is not responsible beyond the amount paid for any errors and omissions contained herein." (7-1-93)

03. Special Exceptions. An insurer may insert such special exception(s) as shall develop from an examination of the title. A special exception shall in all cases specifically describe the item excepted to and shall not be general in terms. The printed provisions of a filed policy form, including exclusions from coverage, exceptions not insured against and stipulations and conditions shall not be deemed special exceptions. (7-1-93)

04. Liens and Encumbrances, Standards of Insurability and Insuring Around. The determination of insurability as to liens and encumbrances under Section 41-2708(1) and the risk prohibited under Section 41-2708(2), Idaho Code, intentionally omitting an outstanding enforceable recorded lien or encumbrance, are interpreted by the Insurance Director to mean: (7-1-93)

a. "Intentionally" omitting an outstanding enforceable recorded lien or encumbrance is the issuance of the policy with the intent to conceal information from any person by suppressing or withholding title information, the consequence of which could result in a monetary loss either to the title insurance company or to the insured under the policy or binder. (7-1-93)

b. "Outstanding enforceable recorded lien or encumbrance" and/or "determination of insurability" as

to possible liens and encumbrances shall not be construed as prohibiting an insurer from issuing a policy without taking exception to a specific recorded, inchoate, or death tax item when sound underwriting standards and practices allow insurance against the item. Defects of title are not regulated by this provision. Specifically, a policy may be issued without taking exception to the following items on the conditions set out: (7-1-93)

i. Where a lien securing an obligation, though not released of record, to the satisfaction of the insurer has been discharged and the insurer or its agent has documentary evidence in its file that the obligation has been paid in full. (7-1-93)

ii. Where funds are in escrow to pay said item and a recordable release in form for filing is available for recording in the ordinary course of business. (7-1-93)

iii. Where liens, in the opinion of counsel, are barred by the statute of limitations. (7-1-93)

iv. Where inchoate liens may arise from improvements to the described property and may have priority over a mortgage being insured and a sufficient indemnity as herein defined has been delivered to and accepted by the insurer, or sufficient funds, including short term treasury bills and notes, have been deposited with the insurer or its agent to assure ultimate payment and release of such liens; provided, an exception as to such inchoate liens shall be shown on the policy with a provision insuring against the enforcement thereof. Sufficient indemnity as used herein shall mean a direct obligation to pay such liens in an amount judged adequate by the insurer executed by a financial institution regulated by the state or federal government or executed by a responsible person as hereinafter defined. This subsection shall also apply to recorded liens being contested if the indemnity is one hundred and fifty percent (150%) of the claim and is by such financial institution or in said funds. (6-30-19)T

v. Where the insurer has previously issued a policy without taking exception to the specific item and is called upon to issue an additional policy where it is already obligated under such prior policy and where the new policy will not increase its liability or exposure; provided, an exception as to such item shall be shown on the policy with a provision insuring against the enforcement thereof. (7-1-93)

vi. When the mortgage policy issued insures validity and priority of a lien, the insurer shall not be required to itemize liens which are subordinate to the lien insured, whether by express subordination or operation of law, unless such subordinated matters must be shown to comply with a policy provision, or unless requested by the insured to do so; provided, when issuing a preliminary report, commitment or a binder for a mortgagee's policy all subordinate liens shall be shown but a statement may be made that they are subordinate. (7-1-93)

vii. With reference to federal estate taxes and state inheritance taxes which have not been paid, where the insurer has examined a balance sheet of the estate and determined more than adequate funds are on hand to pay such taxes, and the insurer has taken an indemnity from a responsible person protecting itself against such unpaid taxes, or where sufficient moneys or other securities to pay such taxes have been placed in escrow pending the payment thereof or pending receipt of waiver of lien from the taxing authority. (7-1-93)

viii. "Responsible person" is one (1), or more than one (1) if they are jointly and severally liable, each of whose current verified balance sheet upon examination is determined by the insurer to be sufficient for the purpose of the indemnity given. Verified copies of all statements shall be retained by the insurer or its agent. (7-1-93)

05. Mechanics' Liens, Prohibited Risk. Under the provisions of Section 41-2708, Idaho Code, the Insurance Director has determined under standards of insurability, prohibited risks and rebates, that under all forms of mortgage policies the risk insured shall not include unrecorded liens and encumbrances, including contractors', subcontractors' professional services, materialmen's and mechanics' liens, unless: (7-1-93)

a. The mortgage shall have been placed of record prior to commencement of any improvement on the premises and the insurer is satisfied that the mortgage and related documents with reference to such priority; or (7-1-93)

b. Unless the provisions of Subsections 005.04.b.ii., 005.04.b.iii. or 005.04.b.iv., and 005.04.b.viii. as applicable have been complied with; or (7-1-93)

c. Unless the insurer has satisfied itself and documented its file that construction has been completed and the time for filing liens has expired. (7-1-93)

06. Usury, Truth in Lending Disclosures. Protection against usury, or disclosures required in consumer credit protection acts, truth in lending acts, or similar acts imposing duties on lenders, do not constitute a part of the issuance of title insurance policies. Title insurers and their agents shall not prepare or pass judgment on documents as to usury nor on disclosure documents and notice of right of rescission documents required by any such acts or make any computations as required therein, in the issuance of title insurance policies; provided, an endorsement to a mortgage policy insuring that the loan is one by definition of the Truth in Lending Act exempt from rescission is permissible. Nothing herein shall prohibit such title insurers or their agents from performing closing or escrow services involving such matters when a proper fee is obtained therefor. (7-1-93)

07. Filing, Approval, Unique Contract or Rate. Whenever a title insurer is requested to insure a unique kind or class of risk for which a premium rate or form of policy or endorsement has not been filed, neither of which lends itself to an advance filing and determination of said rate or form, pursuant to Section 41-2706(4) such title insurer may make a written application to the Director of Insurance for approval of said special rate or form without complying with the filing notice and thirty (30) day waiting provisions of Section 41-2707 upon complying with the following requirements: (7-1-93)

a. The insurer shall not have agreed to the special rates nor agreed to issue the special policy or endorsement, prior to making an application to the Director of Insurance as herein set out. (7-1-93)

b. The insurer shall make a written application to the Director of Insurance, requesting approval of the applicable special rate or special insurance policy or endorsement, wherein the insurer shall set forth why the particular rate or policy or endorsement is unique as to the risk or form, that such item has or has not ever arisen in the past five (5) years to the knowledge of said insurer, and the circumstances if it has previously arisen in said period, and the circumstances which now arise which necessitate said rate, policy or endorsement and an analysis comparing said unique rate, policy or endorsement to the nearest comparable filed rate, policy or endorsement and justifying the difference on the basis of Section 41-2706(1) and (2). Such application shall have attached to it the proposed policy or endorsement form. The Director of Insurance shall have ten (10) working days after the date of receipt of such application to disapprove the same, and the filing shall be deemed effective if the same is not disapproved within such time. The burden is upon the insurer to make inquiry after the expiration after said ten (10) days to determine whether a disapproval has been made, whether or not mailed notice of such disapproval has not yet been received by said insurer. (7-1-93)

c. The provisions hereof are only applicable to rates, policies and endorsements, which by reason of the rarity of the event, or the peculiarity of the circumstances, do not lend themselves to a general advance determination and filing of said item. Applications under this rule and the applicable statute shall not be approved if it appears either that said application does not meet the standards of the statute or is such a deviation from the usual policy form or rate most nearly applicable thereto as to be an unsound underwriting practice or an inadequate premium. (7-1-93)

006. DISCLOSURE BY PRODUCER OF TITLE BUSINESS.

No title entity may accept any order for; issue a title commitment, guarantee, title insurance policy for, or provide services including, but not limited to, escrow closing and foreclosure services, to an applicant if it knows or has reason to believe that the applicant was referred by a producer of title business, where the producer of title business has a financial interest in the title entity to which the business is referred unless the producer of title business has disclosed to the applicant the financial interest of the producer of title business. The disclosure must be made in writing and contain the items required in Section 007 of this rule. (6-30-19)T

007. DISCLOSURE REQUIREMENTS.

01. Disclosure Required By Section 006. Shall be provided to the applicant at the time the sell and/or purchase contract is entered into. A signed copy of the disclosure shall be maintained by the producer of title business and provided to the title entity prior to, or simultaneously with, the placing or the order for a title insurance commitment or guarantee or escrow closing services. The title entity shall maintain a copy of said disclosure for a minimum period of five (5) years. (6-30-19)T

02. Disclosure. Disclosure shall contain a heading, in bold face, all caps, type font 14 or higher that states: "NOTICE OF FINANCIAL INTEREST IN TITLE ENTITY BY PRODUCER OF TITLE BUSINESS."
(6-30-19)T

03. Statement. Disclosure shall contain the following statement in type 12 font or higher: "We call this interest to your attention for disclosure purposes. (Provide name of Producer of Title Business) has a financial interest in this title entity (provide title entity name). This financial interest may result in a conflict of interest in our representation of you. Accordingly, you are free to choose any other title entity which is licensed by the Idaho Department of Insurance in the county in which the property is located. A list of title insurers and title agents licensed in the county in which the property is located may be found by contacting the Idaho Department of Insurance."
(6-30-19)T

04. Chooses to Have Transaction Served. Disclosure shall contain a statement that the Applicant has read the aforementioned disclosure and chooses to have their transaction served by the Title Entity referred by the Producer of Title Business. The disclosure shall contain the signature of all applicants along with the date the signature(s) was accomplished.
(6-30-19)T

008. FINANCIAL INTEREST NOTICE.

01. Names and Addresses of All Producers. A title entity shall notify the Director of the Department of Insurance the names and addresses of all producers of title business that have a financial interest in the title entity, including the financial interest held by the producer of title business and the date the financial interest was acquired.
(6-30-19)T

02. Financial Interest Notice. The title entity will provide the financial interest notice to the Director of the Department of Insurance prior to the granting of a title agent license and upon request for renewal of a title agent license.
(6-30-19)T

009. -- 010. (RESERVED)

011. TITLE INSURANCE AGENTS AND EMPLOYEES ACTING AS ESCROW AGENTS.

01. Written Instructions. An escrow agent shall not accept funds or papers in escrow without a dated, written instruction signed by the parties or their authorized representatives adequate to administer the escrow account and without receiving at the time provided in the escrow instructions sufficient funds and documents to carry out terms of the escrow instructions. Funds and documents deposited shall be used only in accordance with such written instruction; and if additional specific instructions are needed, the agent shall obtain the consent of both parties or such representatives to the escrow or an order of a court of competent jurisdiction at the expense of the escrow parties.
(7-1-93)

02. Notice of Conflict of Interest. An escrow agent shall act without partiality to any of the parties to the escrow. An escrow agent may not close a transaction where he has, directly or indirectly, a monetary interest in the subject property either as buyer or seller. If an escrow agent has a business interest in the escrow transaction other than as escrow agent, the relationship or interest must be disclosed in the written escrow instructions. After noting such interest, an additional statement shall appear as follows: "We call this interest to your attention for disclosure purposes. This interest will not, in our opinion, prevent us from being a fair and impartial escrow agent in this transaction, but you are, nevertheless, free to request the transaction be closed by some other escrow agent." (7-1-93)

03. Closing Statement. On completion of an escrow transaction the agent shall deliver to each principal a written closing statement signed by the agent of each principal's account. The same shall show all receipts and disbursements and any charge made by and disbursements to the escrow agent shall be clearly noted. A copy shall be retained.
(7-1-93)

04. Control of Funds. An escrow agent shall maintain one or more "trust accounts" in a federally insured financial institution into which all escrow funds received shall be deposited and from which there shall be drawn escrow payments. No other funds shall be commingled with such trust account. Escrow fees shall not be drawn

until the escrow is completely ready to close in accordance with the escrow instructions and must be withdrawn not later than the day on which the final disbursements are made for the escrow closing. (7-1-93)

05. Escrow Accounting Procedures. An escrow agent shall maintain on a current basis (a) an escrow ledger with a separate numbered sheet for each escrow agreement and (b) an escrow liability control account. Disbursements shall be posted from checks or other vouchers and each item, not the total of items, must be entered. Escrow liability control account shall balance with the escrow ledger at all times and shall equal the balance of funds in the “trust accounts” for escrows at the bank. Checks may not be drawn against an escrow account without sufficient credit balance for the particular escrow existing at the time. Funds shall not be transferred between escrow agents except by writing checks and receipts which are charged and credited respectively to accounts with the reason noted and the authority therefor. All services must be performed and the escrow account ready to close before any service or escrow fees may be charged and drawn from an escrow account (unless an escrow is a long term collection, and fees are payable monthly or annually). The escrow funds will be placed in the “trust accounts” for escrows and no other funds commingled therewith. All entries in any escrow account shall be posted the date of the entry without regard of the date of posting, but all entries should be posted daily. (7-1-93)

06. Escrow Records. Each escrow agent shall maintain in each escrow transaction: (3-15-02)

a. Evidence of all funds received including copies of all instruments, which shall include prenumbered cash receipts, copies of cashier’s checks, wire transfer confirmations or evidence of unconditional payment of checks, as applicable; (3-15-02)

b. Complete evidence of all funds disbursed which shall include check stubs or check copies, and wire instructions for all disbursements as applicable; and (3-15-02)

c. A final ledger sheet for each escrow transaction listing all items received and disbursed. All records shall be made available for audit, inspection and examination by the Director upon demand, and all records shall be preserved for not less than six (6) years from the closing date of the escrow. (3-15-02)

07. Bond. Before a license shall be issued to a title insurance agent pursuant to Section 41-2710, Idaho Code, such agent must comply with the requirements for a bond for the title insurance agent, escrow officer and any of the employees of said agent thereof engaged in handling escrow accounts and funds or countersigning and issuing title insurance policies, except such employees whose duties are wholly clerical in relation thereto. Such bond need not be renewed each year, but may be in the form that continues from year to year until canceled. Such bond may be for more than one county if the title insurance agent is licensed to do business in more than one county, but the liability under such bond shall be limited to the amount per county as required by Section 41-2711, Idaho Code. Such bond shall be for the benefit of all persons who have suffered any loss because of the breach of the terms of said bond and shall be enforceable on finding of the Director of Insurance upon hearing that the terms of the bond have been violated. Deposits in Lieu of Bonds: In lieu of such bond, cash or securities as herein defined may be deposited with the Director of Insurance. The Director of Insurance does hereby approve the following securities which are eligible for deposit in place of the bond required: Cash in the form of a cashier’s check, any public obligation as defined in Section 41-707 and Section 41-708, Idaho Code, and the assignment of any savings deposits or certificates of deposit as defined in Section 41-720, Idaho Code. In each case, such deposit shall be accompanied by a statement that such deposit is made to meet the compliance of Section 41-2710, Idaho Code, and may be liquidated to meet the obligations of said section. Said cash or security in lieu of the bond shall be deposited with the director pursuant to Section 41-804, Idaho Code, except that the cash shall be deposited with the state treasurer for the account of the bond of said depositing agent. (7-1-93)

08. Cancellation of Bond -- Cancellation of License. A title insurance agent’s bond may provide for cancellation thereof upon notice of not less than thirty days to the Insurance Director and to the licensed agent. Upon such notice being received, the licensed title insurance agent must provide a new bond in place thereof before the cancellation of the current bond, and in the event of failure to do so, the license of the title insurance agent shall be deemed suspended on the date of the expiration of such bond, and until a replacement bond has been issued and delivered to the Director of Insurance. (7-1-93)

09. Disbursement of Funds or Documents From Escrow -- Requirement for Collected Funds. (7-1-93)

a. Definitions. (7-1-93)

i. “Business Day” means a calendar day other than Saturday or Sunday, and also excluding most major holidays. If January 1, July 4, November 11, or December 25 fall on a Sunday, the next Monday is also excluded from the definition of a business day. (7-1-93)

ii. “Collected Funds” means (a) cash (currency); (b) wired funds when unconditionally received by the escrow agent; (c) when identified as such, (1) cashier’s check; (2) certified check; or (3) teller’s check (official check) when any of the above are unconditionally received by the escrow agent; (d) U.S. Treasury checks, postal money orders, federal reserve bank checks, federal home loan bank checks, State of Idaho and local government checks, local or Idaho on-us checks, or local third party checks on the next business day after deposit; (e) local personal or corporate checks on the second business day after deposit; and (f) non-local State and government checks, non-local on-us checks, non-local personal or corporate checks or non-local third party checks on the fifth business day after deposit. For purposes of this section a deposit is considered made on (1) the same day the item is delivered in person to an employee of a federally insured financial institution, or (2) the first business day following an after business hours deposit of an item to a federally insured financial institution. (7-1-93)

iii. “Cashier’s Check, Certified Check and Teller’s Check (Official Check)” as identified above in Subsection 011.10.a.ii. means “checks” issued by a federally insured financial institution. (7-1-93)

iv. “Collection or Long-Term Escrow” means an escrow established for the purpose of receiving two (2) or more periodic payments over a total period of time after establishment in excess of thirty (30) days. (7-1-93)

v. “Escrow” includes any agreement (express, implied in fact or implied at law) pursuant to which funds or documents are delivered to an escrow agent to be held by the escrow agent until the happening of a contingency or until the performance of a condition, and then delivered by the escrow agent to another or recorded by the escrow agent. (7-1-93)

vi. “Escrow Agent” includes any person or entity described in Section 41-2704, Idaho Code, (and the rules promulgated thereunder), which accepts funds or documents for the purpose described in Subsection 011.10.a.v. (7-1-93)

vii. “Incidental Expenses” means direct expenses that are the obligation of one or more of the parties to an escrow transaction but are not the purchaser’s principal obligation. Incidental expenses would include, but not be limited to, advances to cover unexpected recording fees and additional interest occasioned by delays in closings or miscalculations. (7-1-93)

viii. “Local Checks” as identified above in Subsection 011.10.a.ii. means checks drawn against a federally insured financial institution located in the same check processing region as the title agent’s depository federally insured financial institution. (7-1-93)

ix. “On-Us Checks” as identified above in Subsection 011.10.a.ii. means checks drawn against the same federally insured financial institution or branch as the title agent’s own depository federally insured financial institution. (7-1-93)

b. Requirement of Collected Funds. (7-1-93)

i. Notwithstanding any agreement to the contrary, no disbursement of funds or delivery of documents from an escrow for recording or otherwise may be made unless the escrow contains a credit balance consisting of collected funds, other than funds of the escrow agent or its affiliates, sufficient to discharge all monetary conditions of the escrow. The requirement of collected funds does not apply to collection or long term escrows. (7-1-93)

ii. Notwithstanding any other provision of Section 011, an escrow agent may advance its own funds in an aggregate amount not to exceed one thousand dollars (\$1000) to pay incidental expenses incurred with respect to the escrow. (7-1-93)

012. ESCROW FEES.

Title insurers and title insurance agents shall not charge less than the fees filed with the Department of Insurance for a specified escrow service, as such service is defined in the title insurer's or title insurance agent's filed schedule of fees. Each title insurer and title insurance agent shall file its schedule of escrow fees charged for all escrow and closing services rendered on a yearly basis due March 15 reflecting experience from the previous calendar year. Fees should include a title entity's basic rate, minimum rate and negotiable rate with respect to different types of closings and should not reflect credits of any kind with regard to different classifications of customers. The fee shall be based upon the full sales price in the event of a sale, or the amount of the loan in the event of a mortgage and shall not be less than the title entity's cost for providing that service. Fees for escrow and closing services shall not include preparation of instruments. Property in different ownerships always, and noncontiguous properties generally, are rated separately. Additional fees will be charged where the minimum fee is inadequate because of the unusual complications of the transactions. Fees may also be filed throughout the year as often as necessary as determined by the title entity. Fee filings in these instances shall be filed at least thirty (30) days prior to implementation of the fees. (6-30-19)T

013. -- 999. (RESERVED)

**IDAPA 18
TITLE 05
CHAPTER 03**

18.05.03 – REBATES AND ILLEGAL INDUCEMENTS TO OBTAINING TITLE INSURANCE BUSINESS

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to the general rule making authority in Idaho Code, Section 41-211, to aid in the effectuation of Idaho Code, Section 41-2708(3), and Idaho Code, Section 41-1314. (7-1-93)

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.05.03, “Rebates and Illegal Inducements to Obtaining Title Insurance Business.” (3-30-07)

02. Application of Rule. The provisions of this rule apply to all title insurers and title insurance agents. This rule does not limit the Director’s authority to determine that other title insurance trade practices constitute violations of Idaho Code Sections 41-2708(3) and 41-1314. (3-30-07)

03. Purpose. The purpose of this rule is to define certain fair trade practice standards for title insurance, the violation of which will constitute rebates and/or illegal inducements prohibited by Idaho Code, Sections 41-2708(3) and 41-1314. The Department of Insurance regulates the title insurance industry. It does not regulate producers of title business. Rule 18.01.56, “Rebates and Illegal Inducements to Obtaining Title Insurance Business,” will interpret the anti-rebate and anti-illegal inducement statutes as applicable to the title insurance industry. This rule has been thoroughly researched and is based in part on the rules of Idaho’s neighbor states. In addition, written and oral comments and recommendations about the rule as well as testimony provided at five hearings conducted across the state have been carefully reviewed and have contributed to the provisions of IDAPA 18.05.03, “Rebates and Illegal Inducements to Obtaining Title Insurance Business.” This rule is intended to interpret broad anti-rebate and anti-illegal inducement statutes. The rule was drafted after representatives of the title industry and producers of title business industries advised the Department that there was an accumulation of past and present abuses that had previously gone unreported. These entities asked the Department to step in and help rectify the situation and suggested in part that the establishment of guidelines as to what is an inducement and what is an illegal inducement would help stop past and present abuses and curtail future abuses. The guidelines can be referred to in the title entity’s day to day business in interpreting what is an inducement and what is an illegal inducement. This guideline will also help the Department in its efforts to enforce the anti-rebate and anti-illegal inducement statutes. At no time has the Department of Insurance or its representatives stated that the standard practice of the title industry is to give collateral benefits and that the standard practice of the industries of producers of title business are to receive collateral benefits. The Department of Insurance recognizes as an undisputed fact that a producer of title business in most instances is involved with the consumer in assisting the consumer in the selection of a title company for title insurance services. The Department of Insurance also recognizes that abuses in the intricacies of this selection have occurred and do occur, and the occurrence of abuses is specifically acknowledged by the title industry and the Idaho Land Title Association. The Department of Insurance has taken and will continue to take action to reported violations. The Department’s goal is to assure that the selection of a title company is made on the basis of the title company’s ability to provide economy, promptness, accuracy and efficiency in its service. The elimination of “collateral benefits” with the interpretive guidance of IDAPA 18.05.03, “Rebates and Illegal Inducements to Obtaining Title Insurance Business,” will help in accomplishing this goal -- a goal that establishes a uniform set of rules for all title entities and which ultimately benefits the consumer. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of

the Attorney General.” (3-30-07)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, ID 83720-0043. (3-30-07)

04. Web Site Address. The department’s website is <https://doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORD COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Business of Title Insurance. “Business of title insurance” as set forth in Idaho Code, Section 41-2704 and includes in addition thereto, means the performance in this state by a title entity of any service in conjunction with the issuance of any contract or policy of title insurance and/or closing or escrow service.(6-30-19)T

02. Person. “Person” includes any natural person and any firm, association, organization, partnership, business trust, corporation or other legal entity. (7-1-93)

03. Producer of Title Business. “Producer of title business” includes any person engaged in this state in the trade, business, occupation or profession of: (7-1-93)

a. Buying or selling interest in real property; or (7-1-93)

b. Making loans secured by interest in real property; and (7-1-93)

c. Shall include but not be limited to real estate agents, real estate brokers, mortgage brokers, lending or financial institutions, builders, attorneys, developers, subdividers, auctioneers engaged in the sale of real property, consumers, and the employees, agents, representatives, or solicitors of any of the foregoing. (7-1-93)

04. Self Promotional. “Self promotional” refers to either a promotional function which is conducted by a single entity or a promotional item intended for distribution by a single entity. All benefits from the promotional function or item must accrue to the entity promoting itself. (7-1-93)

05. Things of Value. “Things of value” means anything that has a monetary value and includes, but is not limited to, tangible objects, services, use of facilities, monetary advances, extension of lines of credit, creation of compensating balances, and all other forms of consideration. (3-28-18)

06. Trade Association. “Trade association” means an association of persons, a majority of whom are producers of title business, or persons whose primary activity involves real property. (7-1-93)

07. Title Entity. “Title entity” includes both title insurance agents and title insurers and their employees, agents, or representatives. (7-1-93)

011. PROHIBITED THINGS OF VALUE.

A title entity shall not provide things of value to a producer of title business, consumer or member of the general

public except as permitted in Sections 012, 013, 014, and 015 of this chapter. If a providing of things of value does not clearly fit into the rules in Sections 012, 013, 014, and 015, then it is a prohibited act. Exhibit 1, attached hereto, is a partial, but not all-inclusive, list of acts and practices that are considered illegal inducements prohibited by Title 41, Idaho Code (the Idaho Insurance Code). (6-30-19)T

012. PERMITTED CONSUMER INFORMATION.

01. Information That May Be Provided. To facilitate the listing and sale of Idaho property, certain consumer information may be provided without charge to licensed real estate agents and brokers or to a person who owns the property for which the request is made, but is limited to the following information: (3-15-02)

02. Listing Package. A single copy of a “listing package,” “property profile,” or similarly named packet of information. (7-1-93)

a. A “listing package” shall consist of information relating to the ownership and status of title to real property, and may include a single copy of only the following seven (7) items: (3-29-17)

- i. The last deed appearing of record; (7-1-93)
- ii. Deeds of trust or mortgages which appear to be in full force and effect; (7-1-93)
- iii. A plat map reproduction and/or a locator map; (3-15-02)
- iv. A copy of applicable restrictive covenants; (3-15-02)
- v. Tax information; (3-29-17)
- vi. Property characteristics such as number of rooms, square footage and year built; and (3-29-17)
- vii. Photographs, including aerial, of the property. (3-29-17)

b. A “listing package” may include no more than the seven (7) above described items of information and shall not include market value information, demographics, or additions, addenda, or attachments which may be construed as conclusions reached by the title entity regarding matters of marketable ownership or encumbrances. Photographs may be provided, but only if the title entity does not pay a separate fee or provide any other consideration to a person for that product or service. The title entity may provide any photographs that are acquired through normal subscriptions or licensing fees associated with obtaining access to county records for tax information, property characteristics, or plat maps, as long as there is no additional charge to the title entity for the production, reproduction or delivery of the photographs. A generic cover letter with the printed standard letterhead of the title entity may be attached to the “listing package.” The cover letter may include a brief statement identifying by name only, which of the seven (7) permitted items of information are attached thereto. The cover letter may also contain a disclaimer as to conclusions of marketable ownership or encumbrances. The content of the cover letter or “listing package” is strictly limited to the foregoing and shall specifically not include any advertising or marketing for the benefit of the recipient. (3-29-17)

c. Market value information, demographics, additions, addenda, photographs (other than as described in Paragraph 012.02.b) or other attachments, which attachments may be construed as conclusions reached by the title entity regarding matters of marketable ownership or encumbrances, may be provided, but only upon receipt of a charge commensurate with the actual cost of the work performed and the material furnished (See Exhibit 1, #11). (3-29-17)

03. Additional Information That May Be Provided. A title entity may provide to licensed attorneys and licensed appraisers only the following documents without charge; (4-4-13)

- a.** A plat map reproduction; (4-4-13)
- b.** A copy of applicable restrictive covenants; (4-4-13)

- c. The last deed appearing of record; and (3-29-17)
- d. A cover letter as described in Paragraph 012.02.b. (4-4-13)

013. PERMITTED ADVERTISING WITH TRADE ASSOCIATIONS.

01. Advertisements. No advertisement may be placed in a publication that is published or distributed by, or on behalf of, a producer of title business. Advertising in a trade association publication is only permitted if the publication is an official publication, published or distributed by, or on behalf of the trade association with at least regular annual publications. The publications must be nonexclusive (any title entity must have an equal opportunity to advertise in the publication and at a standard rate). The title entity's ad must be purely self-promotional. (3-29-17)

02. Donations. A title entity is permitted to donate time to serve on a trade association committee and may also serve as an officer or director for the trade association. A title entity may also donate, contribute or otherwise sponsor a trade association event if the event is a recognized association event that generally benefits all members and affiliated members in an equal manner. The donation cannot benefit selected producer of title business members of the association unless through random process. Solicitation for the donation must be made of all members and affiliated members in an equal manner. Donations are per agent license or insurer and are limited to a cumulative donation value of two thousand dollars (\$2,000) or equivalent things of value collectively to all trade associations per year. In addition, a title entity is allowed to participate in or attend trade association events as long as the title entity pays a fee commensurate with fees paid by other participants in the events. These events include, but are not limited to, conventions, award banquets, symposiums, breakfasts, lunches, dinners, open houses, sporting activities and all other similar activities. (3-30-07)

014. PERMITTED SELF-PROMOTIONAL ADVERTISING.

01. Self-Promotional Items. A title entity may distribute self-promotional items having an acquisition value of less than twenty-five dollars (\$25) to producers of title business, consumers, and members of the general public. These self-promotional items are limited to novelty gifts, advertising novelties, and generic business forms and specifically do not include food, beverages, gift certificates, gift cards, or other items that have a specific monetary value on their face or that may be exchanged for any other item having a specific monetary value. Self-promotional items shall not contain the name, logo or any reference to a producer of title business, trade association or donee. (6-30-19)T

02. Self-Promotional Functions. Self-promotional functions are limited to the following two (2) types of functions: (3-30-07)

a. Educational programs - a title entity is permitted to conduct educational programs. The education programs must only address title insurance and escrow and other topics related thereto. A title entity is permitted to expend no more than twenty dollars (\$20) per person at an educational program. For purposes of determining the maximum permitted expenditure, all costs associated with the delivery of the educational program shall be considered, including but not limited to, costs paid by the entity for travel, refreshments, instructor or speaking fees and facility rental. A title entity may participate in or make presentations at educational programs which are conducted or presented by other entities. The title entity is not permitted to expend any money to sponsor or cosponsor these programs, unless the educational program is a trade association event in which case Subsection 013.02 of this chapter will apply. (3-29-17)

b. Open houses - a title entity is permitted to have two (2) open houses per year. An open house shall be a self-promotional function at the title entity's owned or occupied facility (i.e. a Christmas party or any party, an open house for remodeling of its facility, an open house for a new building to become the title entity's facility). It shall be nonexclusive (an open invitation to all producers of title business is required). A title entity must not expend more than fifteen dollars (\$15) per guest per open house. A title entity cannot combine permitted expenditures for two (2) open houses to be used for one (1) open house. A title entity also cannot accumulate left over or unused expenditures from one (1) open house and use those expenditures for a second open house. (3-30-07)

015. PERMITTED BUSINESS ENTERTAINMENT.

A title entity shall not expend more than one hundred dollars (\$100) per person per day for all meals and/or events. Meals and events shall include, but not be limited to, breakfast, brunch, lunch, dinner, cocktails, sporting events, sporting activities, trips and music and art events. These meals or events may occur on or off the title entity's premises. In addition, a title entity may entertain no more than four (4) persons who are employed by or agents of any single producer of title business in a single day. Spouses and/or guests of the producers of title business or employees or agents thereof shall be included in the count for purposes of determining the four (4) person maximum. In addition, a person may not be entertained by a title entity more than three (3) days during any ten (10) day period of time. For purposes of determining the maximum permitted expenditure, all costs associated with any meals or events shall be considered. This shall include, but not be limited to, costs paid by the title entity for travel, transportation, hotel, equipment or facility rental, meals, cocktails, refreshments, registration or entry fees and event tickets. Entertainment permitted under this rule may not be conditional upon or compensation for forwarding or directing title business to the title entity. (6-30-19)T

016. LOCALE OF THE TITLE INSURER OR TITLE INSURANCE AGENT EMPLOYEES.

A title entity shall not have any of its employees working in a work space location owned or leased by a producer of title business unless: (7-1-93)

- 01. Bona Fide Agreement.** The space is secured by a bona fide written lease or rental agreement. (7-1-93)
- 02. Separate and Secured Space.** The space is separate from and can be secured against access by other occupants of the premises. (7-1-93)
- 03. Fair Market Rental.** The rental paid for the workspace is consistent with prevailing rental payments for similar space in the market area of the location of the work space. (7-1-93)
- 04. Rental by Trade or Barter Prohibited.** The rental is not dependent on volume of business and is paid only in cash (rental cannot be paid by trade or barter). (7-1-93)
- 05. Premises Open to All Business.** The space is open to the conduct of business with any producer of title business or consumer. (7-1-93)
- 06. Sharing of Employees.** There is no sharing of employees. (7-1-93)
- 07. Common Usage of Spare or Equipment.** There is no common usage of space or equipment between the title entity and the producer of title business without a proportionate share of cost, rent, or expense paid by each party. (7-1-93)

017. PENALTY.

This Section shall emphasize and restate the general penalties authorized pursuant to Title 41, Idaho Code, (the Idaho Insurance Code) for violations of the anti-rebate and anti-illegal inducement laws. (7-1-93)

- 01. Section 41-2708(3), Idaho Code.** Section 41-2708(3) provides that each person and entity giving or receiving a rebate, illegal inducement, or a reduction in rate shall be liable for three (3) times the amount of such rebate, illegal inducement, or reduced rate. In addition to this penalty, a title entity may also be subject to an administrative penalty as outlined below. (7-1-93)
- 02. Section 41-327, Idaho Code.** Section 41-327 provides that the Director may impose an administrative penalty not to exceed five thousand dollars (\$5,000) and/or suspend or revoke an insurer's certificate of authority if the Director finds, after a hearing thereon, that the insurer has either violated or failed to comply with the Insurance Code. (7-1-93)
- 03. Section 41-1016, Idaho Code.** Section 41-1016 provides that the Director may impose an administrative penalty not to exceed one thousand dollars (\$1,000) and/or suspend or revoke an agent's license if the Director finds, after a hearing thereon, that the agent has either violated or failed to comply with the Insurance Code. (3-30-07)

018. DISSEMINATION.

All title entities are instructed to distribute a copy of this rule to every employee that may be engaged in activities requiring knowledge of its contents, and to instruct all employees in its scope and operation. (7-1-93)

019. -- 999. (RESERVED)

EXHIBIT 1

A title entity shall not provide things of value except as provided in Sections 012, 013, 014, and 015 of this rule. The following is a partial, but not all inclusive, list of acts and practices which are considered illegal inducements prohibited by the Idaho Insurance Code:

1. A title entity shall not sponsor any activity off its premises unless the producer of title business bears the entire cost of the activity. A title entity shall not cosponsor, subsidize, contribute fees, prizes, gifts, or otherwise provide things of value for a promotional function off the title entity's premises regardless whether the function is self-promotional or not. Off premises functions/activities include, but are not limited to, meetings, luncheons, dinners, conventions, installation ceremonies, celebrations, outings, or related activities of producers of title business, cocktail parties, hospitality room functions, open house celebrations, dances, fishing trips, motor vehicle rallies, sporting events of all kinds, gambling trips, hunting trips or outings, golf tournaments, artistic performances, and outings in recreation areas or entertainment areas. It shall be the burden of the title entity to be prepared to present documentation to the Department of Insurance that no things of value were provided.

2. A title entity shall not sponsor, subsidize, supply prizes or labor, or otherwise provide things of value for promotional activities of producers of title business. This does not prevent a title entity from attending activities of producers of title business if there is no cost to the title entity other than the title entity's own entry fees, registration fees, meals, etc., and provided that these fees are no greater than those charged to producers of title business.

3. A title entity shall not provide or offer to provide, either directly or indirectly, a compensating balance or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by such lending institution to any such person, or for the express or implied purpose of influencing the placement or channeling of title insurance business by such lending institution.

4. A title entity shall not pay or offer to pay, either directly or indirectly, with respect to any producer of title business for:

a. The services of an outside professional whose services are required by any producer of title business to complete or structure a particular transaction;

b. The salary of an employee of such producer of title business;

c. The salary or any part of the salary of a relative of any producer of title business employed by a title entity, if the payment is in excess of the reasonable value of the work actually performed;

d. A fee for making an inspection or appraisal of property, whether or not the fee bears a reasonable relationship to the services performed;

e. Services required to be performed by any producer of title business in his or her professional capacity (e. g. the drafting of documents that are required to be filed by such producer of title business with the title entity for the initiation of closing and settlement services);

f. Any evidence of title or a copy of the contents thereof which is not produced or issued by the title entity, if the evidence or the title relates to a current transaction;

g. The rent for all or any part of the space occupied by any producer of title business;

- h.** Money, prizes, or other things of value in any kind of a contest or promotional endeavor;
 - i.** Any advertising effort made in the name of, for, or on behalf of any producer of title business;
 - j.** Any business form of any such producer of title business other than a form regularly used in the conduct of the title entity's business, which form is furnished solely for the convenience of the title entity and does not constitute a benefit to the producer of title business; or
 - k.** Any salary, commission, or any other consideration to any employee who is at the same time actively engaged as a real estate licensee in the real property or mortgage brokerage business or is actively engaged in any other business of a producer of title business; or
 - l.** Any fee on behalf of any producer of title business before or after inducing such producer of title business to cancel an order with another title entity.
- 5.** A title entity shall not furnish, or offer to furnish, all or any part of the time or productive effort of any employee of the title entity (example: office manager, escrow officer, secretary, clerk, messenger, etc.) to any producer of title business. This provision is not intended to effect the title entity's day to day business with producers of title business. It is directed at title entity employees being utilized by, or "loaned" out to a producer of title business for the self-promotional interests of the producer of title business.
- 6.** A title entity shall not furnish, or offer to furnish, pay for, or offer to pay for, furniture, office supplies including file folders, telephones, equipment, or automobiles to any producer of title business, or pay for, or offer to pay for, any portion of the cost of renting, leasing, operating, or maintaining any of the aforementioned items.
- 7.** A title entity shall not provide, or offer to provide, non title services (example: computerized bookkeeping, forms management, computer programming, trust accounting) or any similar benefit to a producer of title business, without charging for and receiving a fee commensurate for services provided (e. g. a fee for trust accounting shall be a like fee charged by state or federally chartered banks or savings and loan associations in the local area). This provision also does not prevent title entities from contracting with trade associations to provide non-title services for a profit (i.e. MLS services).
- 8.** A title entity shall not provide gifts or other things of value in excess of fifty dollars (\$50) per year per individual in connection with congratulations or condolences to a producer of title business.
- 9.** A title entity shall not issue a title insurance binder, commitment or preliminary report without an order.
- 10.** A title entity shall not furnish any part of its facility (e. g. conference rooms, meeting rooms, etc.) to a producer of title business or trade association without receiving a fair rental charge commensurate with the average rental for similar facilities in the area.
- 11.** A title entity shall not furnish reports containing publicly recorded information, appraisals, estimates, or income production potential, information kits or similar packages containing information about one or more parcels of real property (other than as permitted in Section 012) helpful to any producer of title business, consumer, or member of the general public without making a charge that is commensurate with the actual cost of the work performed and the material furnished (e. g. "farm packages", lot book reports, tax information, title commitments).
- 12.** Delivery service between a title entity and a producer of title business shall be conducted by the title entity's regular messenger service and shall only involve the delivery of items from a title entity to a producer of title business or from a producer of title business to a title entity.

**IDAPA 18
TITLE 06
CHAPTER 01**

18.06.01 – RULES PERTAINING TO BAIL AGENTS

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to the authority vested in the director under Sections 41-211 and 41-1037 through 41-1045, Idaho Code. (4-7-11)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.06.01, “Rules Pertaining to Bail Agents.” (4-7-11)

02. Scope. The provisions of this rule apply to all bail agents, as defined by Section 41-1038, Idaho Code. This rule is supplementary to other rules and laws regulating insurance producers, and all other rules of the department and provisions of title 41, Idaho Code, applicable to insurance producers shall also apply to bail agents. (4-7-11)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (4-7-11)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, the Idaho Administrative Procedures Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General - General provisions.” (4-7-11)

004. INCORPORATION BY REFERENCE.

There are no documents incorporated by reference. (4-7-11)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-7-11)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-7-11)

03. Street Address. 700 West State Street, 3rd Floor, Boise, ID 83720-0043. (4-7-11)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-7-11)

007. -- 011. (RESERVED).

012. NOTIFICATION REQUIREMENTS.

01. Notice of Changes Required. A bail agent licensed pursuant to Section 41-1039, Idaho Code, shall immediately notify the Department of Insurance in writing of any the following: (4-7-11)

a. Change of bail agent’s name; (4-7-11)

b. Change of bail agent’s current business address; (4-7-11)

- c. Change of bail agent's current business phone number or business e-mail address if any; (4-7-11)
- d. Change of name or address of any surety insurance company for which the bail agent has an active appointment; (4-7-11)
- e. Cancellation by a surety insurance company of a bail agent's authority to write bonds for that company; (4-7-11)
- f. Any new affiliation with a bail bond agency; (4-7-11)
- g. Cancellation of a bail agent's affiliation with a bail agency; (4-7-11)

02. Notice of Legal Proceedings Required. A bail agent shall provide immediate written notice to the Department of Insurance of the filing of any criminal charges against the bail agent. In addition to the foregoing, a bail agent shall provide immediate written notice to the Department of Insurance of any material change in circumstances that would require a different answer than previously provided by the bail agent on the background information section of the Uniform Application for Individual Insurance Producer License/Registration. Upon request by the department, the bail agent shall provide copies of all relevant legal documents relating to the matter and any additional relevant information requested. (4-7-11)

013. CRIMINAL HISTORY CHECKS.

01. Criminal History Check Required. All licensed bail agents must obtain a criminal history records check in connection with the renewal of a bail agent's license and shall bear all costs associated with the records check. (4-7-11)

02. Grounds for Immediate Suspension. For the purpose of determining whether grounds for immediate suspension of a bail agent's license exist under Section 41-1039(4), Idaho Code, a withheld judgment or a plea of nolo contendere shall be considered the same as a conviction or guilty plea. (4-7-11)

014. STACKING OF BONDS PROHIBITED.

A bail agent may submit only one (1) power of attorney with each bail bond submitted to any Idaho court. The face value or face amount of the power shall be equal to or greater than the amount of the bail or bond set by the court in the case for which the bond and power are being submitted. A bail agent shall not attempt to "stack" bonds or powers by submitting more than one (1) power of attorney for any single bond. (4-7-11)

015. NOTIFICATION TO SURETY OF FORFEITURE.

A bail agent shall notify the surety insurance company of any forfeiture, as defined in Section 19-2905, Idaho Code, within ten (10) days of receiving the notice from the court. (4-7-11)

016. (RESERVED)

017. BAIL AGENT FINANCING OF BAIL BOND PREMIUMS.

01. Written Agreement Required. No credit may be extended by any bail agent or surety insurance company for the payment of any bail bond premium without entering into a written agreement. The written agreement for the extension of credit to finance premium must contain at a minimum the following: (4-7-11)

- a. The names of the parties to the credit agreement; (4-7-11)
- b. The amount of premium financed; (4-7-11)
- c. The per annum rate of interest; (4-7-11)
- d. The scheduled premium payment dates; and (4-7-11)
- e. Signatures and dates of signatures of all parties to the credit agreement. (4-7-11)

02. Early Surrender for Failure to Pay. If failure to pay premiums due under a credit arrangement may result in the early surrender of the defendant, that fact must be clearly set forth in the written credit agreement. Early surrender for failure to make premium or interest payments when due must be handled in accordance with Section 41-1044, Idaho Code, and neither the bail agent nor the surety shall be entitled to seek recovery of any amounts unpaid as of the date of surrender. (4-7-11)

03. Collateral for Credit Agreement. If the credit agreement is to be collateralized, the collateral must not be excessive in relation to the amount of premium financed, must be separate and apart from any collateral used in the bail bond transaction, must be described in the credit agreement or in an attachment to the agreement, and must be handled in accordance with Section 41-1043, Idaho Code. (4-7-11)

018. PAYMENT OF FORFEITURE.

It is a violation of Section 41-1329(6), Idaho Code, for a bail surety to intentionally, or with such frequency as to indicate a general business practice, fail to pay a claim for forfeiture after liability for payment has become reasonably clear. Liability for payment upon forfeiture is reasonably clear when a defendant has not appeared or has not been brought before the court within one hundred eighty 180 days after the entry of the order of forfeiture, or a motion to set aside the forfeiture, in whole or in part, has not been filed with the court within five (5) business days after the expiration of the one hundred eighty (180) day period following the order of forfeiture pursuant to the Idaho Bail Act. (4-7-11)

019. -- 999. (RESERVED)

**IDAPA 18
TITLE 06
CHAPTER 02**

18.06.02 – PRODUCERS HANDLING OF FIDUCIARY FUNDS

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to authority granted by Sections 41-211, 41-1024, and 41-1025, Idaho Code. (3-29-17)

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.06.02, “Producers Handling of Fiduciary Funds.” (4-11-06)

02. Scope. This rule will affect “Producers,” as defined in Section 18.05.10.010 of this rule, including bail agents who handle funds held in a fiduciary capacity. (3-29-17)

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for these rules. (4-11-06)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General - General Provisions.” (4-11-06)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (4-11-06)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS --WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-11-06)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-11-06)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (4-11-06)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho. (4-11-06)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Cash Collateral. All funds received as collateral by a producer in connection with a bail bond transaction in the form of cash, check, money order, other negotiable instrument, debit or credit card payment, or other electronic funds transfer, given as security to obtain a bail bond, as referenced in Section 41-1043, Idaho Code. (3-29-17)

02. Fiduciary Fund Account. A financial account established to hold fiduciary funds as provided in Section 016. (4-11-06)

03. Fiduciary Funds. All premiums, return premiums, premium taxes, funds as collateral, and fees received by a producer. Fiduciary funds shall include: (3-29-17)

a. All funds paid to a producer for selling, soliciting or negotiating policies of insurance except for those earned fees recognized by statute as earned by the producer upon receipt which are payable to the producer and not the insurance company, pursuant to Section 41-1030, Idaho Code. (4-11-06)

b. All funds received by a producer from or on behalf of a client or premium finance company that are to be paid to an insurance company, its agents, or to the producer's employer. (4-11-06)

c. All funds provided to a producer by an insurance company or its agents that are to be paid to a policyholder or claimant pursuant to a contract of insurance. (4-11-06)

d. All checks or other negotiable instruments collected by the producer that are made payable to the insurer. (4-11-06)

e. Cash collateral. (3-29-17)

04. Premium. The consideration for insurance by whatever name called, and as more fully defined by Section 41-1803, Idaho Code. (4-11-06)

05. Producer. A person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including, without limitation, bail agents as described in Section 41-1039, Idaho Code. (3-29-17)

06. Receive. To collect or otherwise take actual or constructive possession of fiduciary funds. Receiving, includes but is not limited to, taking possession of money, checks, or other negotiable instruments. If fiduciary funds are in the form of a credit or offset on an account or other liability for the benefit of the consumer, without the producer actually taking possession of the funds, then constructive receipt shall be deemed to have occurred on the due date to the insurer. (4-11-06)

011. -- 013. (RESERVED)

014. FIDUCIARY FUND ACCOUNT.

01. Payable to an Insurer. Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to an insurer as described in Subsection 010.02.d. shall be remitted to the insurer within the time period as set forth in the terms and conditions as required by the insurer, or if not specified, then within twenty one (21) days of receipt. (4-11-06)

02. Payable to a Policyholder. Fiduciary funds that are in the form of a check or another negotiable instrument that is made payable to a policyholder or claimant as described in Subsection 010.02.c. shall be remitted to the policyholder or claimant within fourteen (14) days of receipt or as required by the terms of the policy of insurance, the insurer, or applicable law. (4-11-06)

03. All Other Fiduciary Funds. All other fiduciary funds received by the producer, except as described under Subsections 014.01 and 014.02 must be deposited into a fiduciary fund account according to the following schedule: (4-11-06)

a. If in the form of cash, within seven (7) days of receipt, except that, when a producer holds fiduciary funds in the form of cash that exceed two thousand dollars (\$2,000), such funds must be deposited within three (3) business days. (4-11-06)

b. If in the form of checks, money orders, other negotiable instruments, debit or credit card payments, or other electronic funds transfer, received or collected by the producer, within seven (7) days of receipt, except that the producer may remit such funds to the following: (3-29-17)

i. Another licensed producer or licensed business entity, subject to the time frames of Subsection 014.03.b.; or (4-11-06)

ii. A person designated by the insurer who has the obligation to remit the fiduciary funds to the insurer subject to the time frames of Subsection 014.03.b. (4-11-06)

04. Document the Receipt of Fiduciary Funds. A producer who receives fiduciary funds shall document the receipt of those funds in sufficient detail to determine, at a minimum, the date received, the name of the payee, and the amount received. If the producer receives cash, including cash collateral, the producer shall give the payer a detailed receipt at the time of payment. The receipt shall include an indication that cash was received, the date received, the amount received, the payer's name, the payee's name, the purpose of payment, and any other information important to the transaction. The producer shall maintain the receipt records as records of a transaction, and keep those records for a period of at least five (5) years. (3-29-17)

015. DEPOSIT OF OTHER FUNDS IN ACCOUNT.

A producer may deposit other additional funds for the sole purpose of: (4-11-06)

01. Reserves for Return Premiums. Establishing reserves for payment of return premiums. (3-29-17)

02. Funds to Pay Bank Charges. Advancing funds sufficient to pay bank charges. (3-29-17)

03. Contingencies. For any contingencies that may arise in the business of receiving and transmitting premium or return premium funds or cash collateral (any such deposit is hereinafter referred to as "voluntary deposit"). (3-29-17)

016. TYPES OF ACCOUNTS PERMITTED.

A producer shall maintain the fiduciary funds only in: (4-11-06)

01. Accounts in Federally Insured Financial Institutions. Checking accounts, demand accounts, savings accounts or other accounts in a federally insured financial institution; or (4-11-06)

02. Exceed the Federally Insured Limits. If such funds held exceed the federally insured limits, then in addition to Subsection 016.01, those funds that exceed the federally insured limits may be deposited into the following: (4-11-06)

a. An investment account that invests monies in United States government bonds, United States Treasury certificates or in federally guaranteed obligations; (4-11-06)

b. Money market mutual funds registered with the SEC which are rated AAA by Moody's or AAA by S&P. (4-11-06)

03. Separate Fiduciary Funds Account. Nothing in this rule requires a producer to maintain and hold fiduciary funds in his, her, or its, own separate fiduciary funds account. Nevertheless, each producer is responsible for compliance with the provisions of this rule even if fiduciary funds are maintained in a fiduciary funds account established by another affiliated producer. (4-11-06)

017. ACCOUNT DESIGNATION.

01. Designation of a Fiduciary Fund. A fiduciary fund account shall be so designated on the records of the financial institution. The account shall have a separate account number, a separate check register and its own checks. (4-11-06)

02. Trust Fund Account. The phrase, "Trust Fund Account" shall be displayed on the face of each check drawn on a fiduciary fund account or other similar designation as permitted by the financial institution to identify the checks as being from a fiduciary fund account. (4-11-06)

018. INTEREST EARNINGS.

A fiduciary fund account may be interest-bearing or an investment account in accordance with Section 016. The producer shall maintain records establishing the existence and amount of interest accrued and shall make such records available for examination by the director. (4-11-06)

019. PERMISSIBLE DISTRIBUTION OF FIDUCIARY FUNDS.

Distributions from a fiduciary fund account shall only be made for the following purposes, and in the manner stated: (4-11-06)

01. Remit Premiums. To remit premiums to an insurer or an insurer's designee pursuant to a contract of insurance; (4-11-06)

02. Return Premiums. To return premiums to an insured or other person or entity entitled to the premiums; (4-11-06)

03. Remit Surplus Lines Taxes and Stamping Fees. To remit surplus lines taxes and stamping fees collected to the appropriate state; (4-11-06)

04. Reimburse Voluntary Deposits. To reimburse voluntary deposits made by the producer to the extent that the funds in the fiduciary account exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous voluntary deposit. (4-11-06)

05. Transfer or Withdraw Accrued Interest. To transfer or withdraw accrued interest to the extent that fiduciary fund account funds exceed the amount necessary to meet all fiduciary obligations, only if the reimbursement can be matched and identified with the previous interest deposit by the financial institution. (4-11-06)

06. Transfer or Withdraw Actual Commissions. To transfer or withdraw actual commissions and those earned fees recognized as earned by the producer, upon receipt, which are payable to the producer, only if the commissions and fees can be matched and identified with funds previously deposited in the fiduciary account. (4-11-06)

07. Pay Charges Imposed. To pay charges imposed by the financial institution that directly relate to the operation and maintenance of the fiduciary funds account to the extent that fiduciary account funds exceed fiduciary obligations; and (4-11-06)

08. Transfer Funds. To transfer funds from one (1) fiduciary fund account to another fiduciary fund account. (4-11-06)

09. Return Cash Collateral. To return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, has been discharged. (3-29-17)

10. Convert Cash Collateral. To convert cash collateral where the defendant or other responsible party fails to satisfy the obligation of the bail bond and the bail or obligation was not exonerated by the court but instead executed by the court, provided such conversion is compliant with the contract between the producer and the person who deposited the cash collateral. (3-29-17)

020. AUDIT OF FIDUCIARY FUNDS.

A producer shall make all records of collections for, deposits to and disbursements from each fiduciary fund account, as well as any related records accessible to the director for purposes of examination and audit or other general inquiry. (4-11-06)

021. PROHIBITED PRACTICES.

A producer shall not use fiduciary funds for personal use, including but not limited to: (4-11-06)

01. Use Fiduciary Funds as a Personal Asset. Using or allowing other persons to use fiduciary funds as a personal asset, or as collateral for a personal or business loan; (4-11-06)

02. Misreporting Fiduciary Funds. Reporting fiduciary funds on a financial statement without recording an equivalent liability and disclosing through a footnote that the fiduciary funds are not available for use by the reporting entity; (4-11-06)

03. Withhold Issue of Money From a Fiduciary Fund Account. Authorizing a financial institution to withhold issue of money from a fiduciary fund account unless required by a court order; or (4-11-06)

04. Seize Money from a Fiduciary Fund. Authorizing a financial institution to seize money from a fiduciary fund account unless required by a court order. (4-11-06)

022. TIMELY DISBURSEMENT OF FIDUCIARY FUNDS.

In addition to the requirements of Section 014, after receiving fiduciary funds, a producer shall: (4-11-06)

01. Remit Premiums. Remit premiums directly to an insurer or an insurer's designee within the time period as set forth in the terms and conditions as required by the insurer, or if not specified, within fourteen (14) days of receipt; (4-11-06)

02. Return Money Received. Return to the payer the money received as a premium deposit which is retained by the producer or returned to the producer by the insurer to the payer by the earlier of: (4-11-06)

a. Fourteen (14) days from the date the premium is received by the producer from the insurer, or (4-11-06)

b. Fourteen (14) days from the date the insurer notifies the insurance applicant that coverage has been denied if the producer retained the premium deposit. (4-11-06)

03. Refund Received from the Insurer. Issue a refund received from the insurer within fourteen (14) days by disbursing money to the insured or other party entitled thereto by notifying the insured that the refund is being applied to an outstanding amount owed or to be owed by the insured. If the producer is applying the refund to an outstanding amount owed by the insured, the producer shall obtain the insured's permission and provide the insured a detailed description of the amount owed to which the refund is being applied. (4-11-06)

04. Dispute of Entitlement of Funds. If there is a dispute as to entitlement of funds under Subsections 022.01 or 022.03, notify the parties of the dispute and seek to resolve the dispute and document the steps taken to resolve the dispute. (4-11-06)

05. Funds Held for More Than Ninety Days. If fiduciary funds within the scope of Subsections 022.01 or 022.03 are held for more than ninety (90) days, investigate to determine the entitlement to fiduciary funds and pay those fiduciary funds when due to the appropriate person in accordance with this section. (4-11-06)

06. Return Cash Collateral. Return cash collateral to the person who deposited the cash collateral with the producer within fourteen (14) days of the date notice is received that the obligation, the satisfaction of which was secured by the cash collateral, is discharged. (3-29-17)

023. VIOLATIONS.

Any violation of this rule may subject a producer to any sanction authorized pursuant to Section 41-1016(1), Idaho Code. (4-11-06)

024. - 999. (RESERVED)

**IDAPA 18
TITLE 06
CHAPTER 03**

**18.06.03 – RULES GOVERNING DISCLOSURE REQUIREMENTS FOR
INSURANCE PRODUCERS WHEN CHARGING FEES**

000. LEGAL AUTHORITY.

The statutory authority for this rule is Section 41-211, Idaho Code. (5-3-03)

001. TITLE AND SCOPE.

01. Title. The title of this chapter is IDAPA 18.06.03, “Rules Governing Disclosure Requirements For Insurance Producers When Charging Fees.” (5-3-03)

02. Scope. This chapter applies to all resident and non-resident insurance producers who charge a fee to consumers as authorized by Section 41-1030, Idaho Code, and who: (5-3-03)

a. Sell, solicit, or negotiate insurance in Idaho, or to Idaho residents, or regarding subjects of insurance located in Idaho, or otherwise where a license by the director is required; or (5-3-03)

b. Offer advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages under any policy of insurance that could be issued in Idaho. (5-3-03)

002. WRITTEN INTERPRETATIONS.

There are no written interpretations of these rules. (5-3-03)

003. ADMINISTRATIVE APPEALS.

Any administrative appeal regarding this chapter will be made in accordance with Chapter 2, Title 41, Idaho Code, and to the extent not in conflict therewith, Chapter 52, Title 67, Idaho Code, as well as IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General,” promulgated by the Office of the Attorney General. (5-3-03)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (5-3-03)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS -- WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m., except Saturday, Sunday and legal holidays. (5-3-03)

02. Mailing Address. PO Box 83720, Boise, Idaho 83720-0043. (5-3-03)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (5-3-03)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (5-3-03)

007. -- 010. (RESERVED)

011. DISCLOSURE REQUIREMENTS.

01. Before Charging a Fee. Before charging a fee to a consumer, a retail producer shall furnish to each consumer a written disclosure statement containing at least the following information: (5-3-03)

a. A description of the nature of the work to be performed by the insurance producer. (5-3-03)

b. The fee schedule and any other expenses that the insurance producer charges, and whether fees may be negotiated. (5-3-03)

02. Prior Information Disclosure. A retail producer shall disclose information required under this chapter to each consumer to whom a fee will be charged prior to engaging in any act for or on behalf of the consumer where a license is required under Section 41-1004, Idaho Code. (5-3-03)

03. Fee for Intended Services. A retail producer may charge a fee for those services that are intended to be provided and that are not contingent upon some future event occurring outside of the terms of the insurance contract. (5-3-03)

04. Non-Chargeable Fee. A retail producer may not charge a fee for services in connection with statutorily mandated insurance coverage. (5-3-03)

012. INSURANCE PRODUCER FEE DISCLOSURE FORM IN A MANNER PROSCRIBED BY THE DIRECTOR AND POSTED ON DEPARTMENT WEBSITE.

INSURANCE PRODUCER FEE DISCLOSURE

Date: _____

Consumer: _____ Name
Street Address
City, State Zip

Retail Producer: Name
Insurance Agency
Street Address
City, State Zip
(Area Code) Telephone Number
License No.
Firm No.

Services To Be Provided: Financial Planning and research and recommendation on health care, disability, long-term care and life insurance coverage. Completion of forms for medical savings account.

Date Work Is To Be Completed By: _____

Fee Schedule:	Financial Plan	_____	\$
	Research and Recommend Coverage		\$ _____
	Total		\$ _____

Fee(s) Negotiated:	Yes	No	
Type of Other Fee(s) Received (Optional):		Life Commissions	\$ _____
		Disability Commissions	\$ _____
		Long-Term Care Commissions	\$ _____

Qualifications - Occupational/ Educational Background (Optional):

Twenty-five years as a licensed agent in all lines of insurance. Securities licensed in 1986. Designated as Certified Financial Planner 1990. Twelve years' experience in financial planning, college education in accounting and economics. Other designations include CLU and FLMI.

CLIENT ATTESTATION:

By signing below I acknowledge that I have reviewed the information provided in this disclosure and have received a copy of this form.

Client Signature _____ Date _____

I attest that I have disclosed all relevant facts concerning services to be provided and the fees, charges or commissions that will be charged or received for providing the services described.

Producer's Signature _____ Date _____

(5-3-03)

013. -- 999. (RESERVED)

**IDAPA 18
TITLE 06
CHAPTER 04**

18.06.04 – CONTINUING EDUCATION

000. LEGAL AUTHORITY.

The statutory authority for this rule is set forth in Sections 41-211, 41-1013, 41-1108, 41-5813, and 41-5820, Idaho Code. (4-11-15)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.06.04, “Continuing Education.” (4-11-15)

02. Scope. The purpose of this rule is to help protect the public by maintaining high standards of professional competence in the insurance industry and to maintain and improve the insurance skills and knowledge of producers, adjusters, and public adjusters licensed by the Department of Insurance by prescribing a minimum education in approved subjects that a licensee must periodically complete, procedures and standards for the approval of such education, and a procedure for establishing that continuing education requirements have been met. (4-11-15)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-11-15)

003. ADMINISTRATIVE APPEALS.

Any administrative appeal regarding this chapter should be made in accordance with Title 41, Chapter 2, Idaho Code, and to the extent not in conflict therewith, Title 67, Chapter 52, Idaho Code, as well as IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (4-11-15)

004. INCORPORATION BY REFERENCE.

There are no documents to be incorporated by reference. (4-11-15)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (4-11-15)

02. Mailing Address. P.O. Box 83720, Boise ID 83720-0043. (4-11-15)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (4-11-15)

04. Web Site Address. The department's website is <http://www.doi.idaho.gov>. (4-11-15)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (4-11-15)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Licensee. As used in this rule a “licensee” means an individual holding a license as a producer, adjuster, or public adjuster pursuant to Title 41, Chapters 10, 11, or 58, Idaho Code. (4-11-15)

011. APPLICABILITY.

01. Applicability to Certain Insurance Professionals. This rule applies to all resident licensees

except for producers licensed to sell only “limited lines (other than crop) insurance” as defined by Title 41, Chapter 10, Idaho Code. (4-11-15)

02. High Standards for Programs. The Department of Insurance anticipates and expects that licensees will maintain high standards of professionalism in selecting quality education programs to fulfill the continuing education requirements set forth herein. (7-1-93)

012. BASIC REQUIREMENTS.

01. Proof of Completion. As a condition for the continuation of a license, a licensee must furnish the Director of the Department of Insurance (“Director”), on or before the licensing renewal date, proof of satisfactory completion of approved subjects or courses meeting the following requirements: (4-5-00)

a. Twenty-four (24) hours of continuing education credit during each licensing period, which licensing period is for two (2) years. (3-20-04)

b. At least three (3) hours of continuing education credit in ethics must be earned each licensing period. (4-7-11)

c. No more than four (4) hours of continuing education credit from courses approved for adjusters or public adjusters shall apply toward the continuation of a producer license. (4-11-15)

02. Relicensing Procedures After Voluntary Termination of License. A licensee who voluntarily terminates his/her license can apply to be relicensed without testing if the application is received by the Department within twelve (12) months after the termination and if the continuing education requirements were completed during the licensing period prior to voluntary termination. Non-resident licensees who were former resident licensees and who wish to obtain a resident license once again will be subject to the continuing education requirements on a pro-rata basis. (4-11-15)

03. Completion Within Two Years. Each course to be applied toward satisfaction of the continuing education requirement must have been completed within the two (2) year period immediately preceding renewal of the license. Courses may not have been duplicated in the same renewal period. The date of completion for a self-study course is the date of successful completion of exam. (3-20-04)

013. EXCEPTIONS/EXTENSION.

01. Excepting and Extension. The following exceptions and extensions may be made to the continuing education rules: (7-1-93)

a. Licensees on extended active duty with the Armed Forces of the United States for the period of such duty and all other exceptions allowed under Section 41-1008(4), Idaho Code. (5-3-03)

b. Persons which hold a temporary license as provided in Section 41-1015, Idaho Code. (5-3-03)

c. Other exceptions and extensions, where good cause exists, as approved by the Continuing Education Advisory Committee or the Director. (4-5-00)

02. Age Exception or Extension. No exception or extension shall be made solely because of age. (7-1-93)

03. Application for Exception or Extension Required. Licensees requesting exceptions and extensions pursuant to this Rule must apply prior to the renewal date to the Director, in writing, and set forth the basis for the exception or extension. (7-1-93)

014. CONTINUING EDUCATION ADVISORY COMMITTEE.

01. Continuing Education Advisory Committee. An eleven (11) member Continuing Education

Advisory Committee, comprised of representatives from each segment of the insurance industry, shall be appointed by the Director. The committee shall be appointed as follows: (7-1-98)

- a. Five (5) of the members to serve a term of two (2) years and six (6) of the members to serve a term of three (3) years. (7-1-98)
- b. Subsequent committee members shall serve a term of three (3) years. (7-1-98)
- c. Members may succeed themselves if: (7-1-98)
 - i. Renominated by the industry and approved by the Director; or (7-1-98)
 - ii. Reappointed by the Director. (7-1-98)

02. Duties of the Advisory Committee. The advisory committee shall perform the following duties at the discretion of the Director: (7-1-98)

- a. Approve or disapprove programs as per the standards of this rule; (7-1-93)
 - b. Assign the number of continuing education hours to be awarded to programs that are approved; (7-1-93)
 - c. Consider applications for exceptions and extensions as permitted under Section 013 of this rule; (7-1-93)
- and
- d. Consider other related matters as the Director may assign. (7-1-93)

03. Quorum. Those present at any meeting of the Continuing Education Advisory Committee shall be deemed to be a quorum for purposes of acting to perform the duties of the Committee pursuant to this rule. Matters before the Continuing Education Advisory Committee may be decided by a majority of those members present. In the event of a tie vote, the Chairman shall vote to break the tie. (7-1-93)

04. Decisions or Rulings. Decisions or rulings of the Continuing Education Advisory Committee in its performance of the duties set forth herein shall have the effect of decisions or rulings of the Director of the Department of Insurance. Such decisions are, however, in the discretion of the Director, subject to his review and approval or rejection. (7-1-93)

015. PROGRAM REQUIREMENTS.

All continuing education programs are subject to review and approval by the Continuing Education Advisory Committee and certification by the Director. They must be submitted to the Continuing Education Advisory Committee in accordance with Section 021 of this rule on forms promulgated by the Director. Any course provider that resides in, and has had their continuing education program(s) approved by, a state in which the insurance department has signed the Midwest Zone Declaration Regarding Continuing Education Course Approval or has signed a separate reciprocity agreement with the Idaho Department of Insurance, need not have their continuing education program(s) reviewed and approved by the Idaho Continuing Education Advisory Committee. However, prior to offering the course for continuing education credit, all courses must be filed with the department on a form approved by the director and course application fees paid. (5-3-03)

016. PROGRAMS WHICH QUALIFY.

01. Requirements of Acceptable Program. A specific program will qualify as an acceptable continuing education program if it is a formal program of learning which contributes directly to the professional competence of a licensee. It will be left to each individual licensee to determine the course of study to be pursued. All programs must meet the standards outlined in Section 018. (7-1-93)

02. Subjects Which Qualify. (7-1-93)

a. The following general subjects are acceptable for producers as long as they contribute to the knowledge and professional competence of an individual licensee as a producer and demonstrate a direct and specific application to insurance. (4-11-15)

- i. Insurance, annuities, and risk management. (7-1-93)
- ii. Insurance laws and rules. (7-1-93)
- iii. Mathematics, statistics, and probability. (7-1-93)
- iv. Economics. (7-1-93)
- v. Business law. (7-1-93)
- vi. Finance. (7-1-93)
- vii. Taxes, Trusts, Estate Planning. (4-5-00)
- viii. Business environment, management, or organization. (7-1-93)
- ix. Securities. (7-1-98)

b. The following general subjects are acceptable for adjusters and public adjusters as long as they contribute to the knowledge and professional competence of an individual licensee as an adjuster or public adjuster and demonstrate a direct and specific application to adjusting. (4-11-15)

- i. Insurance. (3-19-10)
- ii. Insurance laws and rules. (3-19-10)
- iii. Mathematics, statistics, and probability. (3-19-10)
- iv. Economics. (3-19-10)
- v. Business law. (3-19-10)
- vi. Restoration. (3-19-10)
- vii. Communications. (3-19-10)
- viii. Arbitration. (3-19-10)
- ix. Mitigation. (3-19-10)
- x. Glass replacement and/or repair. (3-19-10)

c. Areas other than those listed above may be acceptable if the licensee can demonstrate that they contribute to professional competence and otherwise meet the standards set forth in this rule. The responsibility for substantiating that a particular program meets the requirements of this rule rests solely upon the licensee. (7-1-93)

017. PROGRAMS WHICH DO NOT QUALIFY.

- 01. Any Course Used to Prepare for Taking an Insurance Licensing Examination. (7-1-93)**
- 02. Committee Service of Professional Organizations. (7-1-93)**
- 03. Computer Science Courses. (7-1-93)**

- 04. Motivation, Psychology, or Selling Skills Courses.** (7-1-93)
- 05. Reviews, Quizzes and/or Examinations.** (7-1-93)
- 06. Any Program Not in Accordance with This Rule.** (7-1-93)

018. STANDARDS FOR CONTINUING EDUCATION PROGRAMS.

In order to qualify for credit, the following standards must be met by all continuing education programs: (7-1-93)

- 01. Program Development.** (7-1-93)
 - a.** The program must have significant intellectual or practical content to enhance and improve the insurance knowledge and professional competence of participants. (7-1-93)
 - b.** The program must be developed by persons who are qualified in the subject matter and instructional design. (7-1-93)
 - c.** The program content must be current or up to date. (7-1-93)
- 02. Program Presentation.** (7-1-93)
 - a.** Instructors must be qualified, both with respect to program content and teaching methods. Instructors will be considered qualified if, through formal training or experience, they have obtained sufficient knowledge to instruct the course competently. (7-1-93)
 - b.** The number of participants and physical facilities must be consistent with the teaching method specified. (7-1-93)
 - c.** All programs must include some means for evaluating quality. (7-1-93)

019. MEASUREMENT OF CREDIT.

- 01. Credits Measured in Full Hours.** Professional education courses shall be credited for continuing education purposes in full hours only. The number of hours shall be equivalent to the actual number of contact hours which must include at least fifty (50) minutes of instruction or participation. As an example, a program will be granted eight (8) hours of credit if the total lapsed time is approximately eight (8) hours and the contact time is at least four hundred (400) minutes. The approved credit hours assigned a course determines the number of hours participants are required to complete. No credit will be given for partial attendance. (7-1-93)
- 02. College Courses.** University or college upper division credit or noncredit courses shall be evaluated as follows: (7-1-93)
 - a.** Credit courses -- each semester system credit hour shall not exceed fifteen (15) hours toward the requirement; each quarter system credit hour shall not exceed ten (10) hours. The final number of credits shall be determined by the Continuing Education Advisory Committee. (7-1-93)
 - b.** Non-credit courses -- number of credits to be determined by the Continuing Education Advisory Committee. (7-1-93)
- 03. Internet Courses.** Internet self-study courses will be credited one (1) hour of continuing education for every fifty (50) minutes of study material, excluding exams. Credit will be given based on the information received in accordance with Section 021 of these rules. (3-19-10)
- 04. Webinar Courses.** Webinars will be credited as classroom instruction or participation. In the event one course encompasses multiple webinars and self-study is required between webinars, the self-study material must be submitted to the Continuing Education Advisory Committee to be evaluated for additional credit in accordance

with Section 021 of these rules. (3-19-10)

05. Power Point Courses. Power point course presentations will be evaluated as follows: (3-19-10)

a. Each power point slide must be accompanied by a timed outline of the subject matter to be presented. (3-19-10)

b. Credit will be given based on the information received in accordance with Section 021 of these rules. (3-19-10)

020. CONTROLS AND REPORTING.

01. Course List Required Upon Renewal. The application for renewal of a license shall be accompanied by a form designated and furnished by the Director, listing the courses that have been taken and are in compliance with this rule. (5-3-03)

02. Licensee to Retain Original Certificate as Evidence. The original certificate of completion received for each educational program or course shall be retained by the licensee as evidence of completion of the program or course for the most recent two (2) year renewal period. The certificates of completion shall be on a form promulgated by the Director. (7-1-93)

03. Statement Subject to Audit. The continuing education statement submitted by a licensee will be reviewed by the Department of Insurance and may be verified by a formal audit on a sample basis. If a continuing education statement submitted by an applicant for license renewal, as required by this rule, is not approved, the applicant shall be notified and administrative action shall be taken pursuant to Sections 41-1013 and 41-1016, Idaho Code. (5-3-03)

04. Responsibility That Course Acceptable on Licensee. The responsibility for establishing that a particular course or other program for which credit is claimed is acceptable and meets the continuing education requirements set forth in this rule rests solely on the licensee. (7-1-93)

05. Sign-In and Sign-Out Sheets. Sign-in and sign-out sheets are to be used and monitored to ensure attendance for the full length of the seminar. No Certificate of Completion is to be given to any one arriving late or leaving prior to the conclusion of the seminar. Failure to comply with these requirements will result in loss of certification in accordance with Section 023. (7-1-93)

021. APPROVED PROGRAMS OF STUDY - CERTIFICATION BY DIRECTOR.

01. Requirements of Course Approval. All courses must be approved by the Continuing Education Advisory Committee and certified by the Director, except as noted under program requirements pursuant to Section 015. If a course is not approved in advance of presentation, an application for credit must be submitted to the Continuing Education Advisory Committee within sixty (60) days of completion of the course on forms promulgated by the Director, with the exception of an individual licensee who may submit an application for courses completed within one hundred eighty (180) days of the course completion date and at least thirty (30) days prior to the license expiration date. All correspondence courses or individual study programs must be approved and certified in accordance with Section 024 prior to being offered to licensees for continuing education credit. (3-19-10)

02. Nonrefundable Application Fee. Each course application shall be accompanied by a nonrefundable application fee (as set forth in IDAPA 18.01.02, "Schedule of Fees, Licenses and Miscellaneous Charges"). (7-1-93)

03. Course Approval Procedures. Any individual, school, insurer, industry association, or other organization intending to provide classes, seminars, or other forms of instruction as approved subjects shall apply for such approval to the Director on forms approved by the Director or on other forms which provide information including but not limited to the following: (5-3-03)

a. A specific outline and/or course material; (7-1-93)

- b. Time schedule; (7-1-93)
- c. Method of presentation; (7-1-93)
- d. Qualifications of instructor; and (7-1-93)
- e. Other information supporting the request for approval. (7-1-93)

04. Method to Determine Completion Required. The submission shall include a statement of the method used to determine the satisfactory completion of an approved subject. Such method may be a written examination, a written report by the agent, certification by the providing organization of the agent's program attendance or completion, or other methods approved by the Director as appropriate for the subject. (7-1-93)

05. Final Acceptance/Rejection of Program. Except as noted under Section 015, all continuing education course material received will be submitted to the Continuing Education Advisory Committee who will approve or deny the course or program as qualifying for credit, indicate the number of hours that will be awarded for approved subjects, and refer the class, seminar, or program to the Director for his certification. In cases of denial, the Continuing Education Advisory Committee will furnish a written explanation of the reason for such action. (5-3-03)

06. List of Programs Certified Acceptable. The Director will provide, upon request, a list of all programs currently available which the Department of Insurance has certified. (7-1-93)

07. Certification of Program. Certification of a program may be effective for a period of time not to exceed two (2) years or until such time as any material changes are made in the program, after which it must be resubmitted to the Continuing Education Advisory Committee for its review and approval. (7-1-93)

08. Advertising Programs Prior to Certification. If any course has not been approved and certified by the Director before the date on which it is to be presented, the course may be advertised or presented as "continuing education credits have been applied for" but shall not be represented or advertised in any manner as "approved" for continuing education credit. (5-3-03)

022. PROOF OF COMPLETION.

Upon completion of a class, program, or course of study, the authorized representative of the sponsoring organization shall, within thirty (30) days of completion of the course: (3-19-10)

01. Certificate of Completion. Provide a certificate of completion to each individual who satisfactorily completes the class, program, or course of study; and (7-1-93)

02. Certification of Attendees Completion. Certify to the Director electronically a list of all such individuals. (3-19-10)

023. APPROVED SUBJECTS - LOSS OF CERTIFICATION.

01. Program Suspension. The certification of a program may be suspended by the Director if it has been determined that: (7-1-93)

a. The program teaching method or program content no longer meets the standards of this rule, or have been significantly changed without notice to the Director for recertification; or (7-1-93)

b. The program certified to the Director that an individual had completed the program in accordance with the standards furnished for certification or completion of the program, when in fact the individual had not done so; or (7-1-93)

c. Individuals who have satisfactorily completed the program of study in accordance with the standards furnished for certification or completion were not so certified by the program; or (7-1-93)

d. The instructor or sponsoring organization is not qualified as per the standards of this rule or lacks education or experience in the subject matter of the proposed course; or (5-3-03)

e. The instructor, sponsoring organization, or any company or affiliate of a sponsoring organization has had a license revoked or suspended in any jurisdiction. This includes any firm or organization where a revoked or suspended individual has a substantial ownership interest, or other control in a firm or organization; or (5-3-03)

f. There is other good and just cause why certification should be suspended. (7-1-93)

02. Reinstatement of a Suspended Certification. Reinstatement of a suspended certification will be made upon the furnishing of proof satisfactory to the Continuing Education Advisory Committee or the Director, in the case of courses approved per Section 015, that the conditions responsible for the suspension have been corrected. (5-3-03)

024. CREDIT FOR INDIVIDUAL STUDY PROGRAMS.

01. Requirements for Credit of Independent Study Programs. All approved correspondence courses or independent study programs must include an examination which requires a score of seventy percent (70%) or better to earn a certificate of completion. For each approved course, the sponsoring organization shall maintain multiple tests (two (2) or more) sufficient to maintain the integrity of the testing process. A written explanation of test security and administration methods shall accompany the course examination materials. Each unit and/or chapter of a course must contain review questions that must be answered with a score of seventy percent (70%) or better before access to the following unit/chapter is allowed. (4-7-11)

02. Completed Tests. The examinations shall be administered, graded, and the results recorded by the organization to which approval was originally granted. Completed tests shall be retained by the sponsoring organization and shall not be returned to any licensee. (4-7-11)

03. Prior Approval Required for Independent Study Programs. All correspondence courses or individual study programs must be submitted for approval and must be approved prior to being offered to licensees for continuing education credit. (7-1-93)

04. Time Period for Credit. Credit will be allowed only in the renewal period in which the course is completed. (7-1-93)

025. CREDIT FOR SERVICE AS LECTURER, DISCUSSION LEADER, OR SPEAKER.

Credit for Instructor. One (1) hour of continuing education credit will be awarded for each hour completed as an instructor or discussion leader, provided the class or program is certified by the Director and meets the continuing education requirements of those attending. (3-19-10)

026. CREDIT FOR BREAKFAST, LUNCHEON, OR DINNER MEETINGS.

Courses, seminars, or programs presented in connection with breakfast, lunch, or dinner meetings may qualify for continuing education credit only if they are meetings of recognized insurance organizations and meet the requirements of Sections 015 and 016. (7-1-93)

027. -- 999. (RESERVED)

**IDAPA 18
TITLE 06
CHAPTER 05**

18.06.05 – MANAGING GENERAL AGENTS

000. LEGAL AUTHORITY.

This rule chapter is promulgated pursuant to authority granted in the Managing General Agent Act (MGA Act), Chapter 15, Title 41, Idaho Code, as well as, the authority granted by Chapter 2, Title 41, Idaho Code, and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

This rule chapter is promulgated to implement and administer provisions of the MGA Act. (7-1-93)

002. -- 003. (RESERVED)

004. DEFINITIONS.

01. Applicability of Statutory Definitions. The definitions contained in the MGA Act as set forth in Section 41-1502, Idaho Code, apply in the construction of this rule chapter in addition to the definitions contained herein. (7-1-93)

02. Bond. “Bond” means a surety bond in an amount delineated in Subsection 013.01 to be held in trust for the benefit and protection of insurers whose money the MGA handles. (7-1-93)

03. Errors and Omissions Policy. “Errors and Omissions Policy” means a policy of insurance providing coverage for claims arising out of the MGA’s negligent acts, errors or omissions. (7-1-93)

04. Department. The Idaho Department of Insurance. (7-1-93)

05. Director. The Director of the Idaho Department of Insurance. (7-1-93)

005. -- 010. (RESERVED)

011. NOTICE PROVISIONS.

01. Notice by MGA. MGA: Within sixty (60) days of the implementation of this rule chapter any person, firm, association or corporation acting in the state of Idaho in the capacity of an MGA as defined in Section 41-1502(3), Idaho Code, must provide notice to the Director of the Department. Notice shall include: (7-1-93)

a. A certified copy of the surety bond required by Subsection 013.01. (7-1-93)

b. Proof of insurance coverage as required by Subsection 013.02. (7-1-93)

c. The appropriate nonrefundable designation fee required by IDAPA 18.01.02. (7-1-93)

d. A list of all names and addresses of insurers doing business in the State of Idaho or Idaho domestic insurers with which the MGA has a contract and a verified statement on a form provided by the Department that the contract(s) contain the provisions required by Section 41-1504, Idaho Code. (7-1-93)

02. Notice by Insurer. (7-1-93)

a. Foreign and Alien Insurers: Within sixty (60) days of the implementation of this rule chapter, and thereafter, within thirty (30) days of entering into a contract with any person, firm, association or corporation meeting the definition of a MGA as provided in Section 41-1502(3), Idaho Code, and if, pursuant to the terms of the contract the MGA will be providing services to the insurer within the State of Idaho, the insurer must provide notification of the appointment of the MGA to the Director of the Department. (7-1-93)

b. Domestic Insurers: Within sixty (60) days of the implementation of this rule chapter, and thereafter, within thirty (30) days of entering into a contract with any person, firm, association or corporation meeting the definition of a MGA as provided in Section 41-1502(3), Idaho Code, the insurer must provide notification of the appointment of the MGA to the Director of the Department. (7-1-93)

c. In addition to those items specified in 41-1505(5), notice by the insurer shall include: (6-30-19)T

i. The name and address of the MGA; (7-1-93)

ii. Proof that the MGA has met the bonding and insurance requirements of Section 013; (7-1-93)

iii. Procedures and timetable for conducting an onsite review of the underwriting and claims processing operation of the MGA as required by Section 41-1505(3), Idaho Code; and (7-1-93)

iv. The name of an officer of the insurer responsible for the contract. (7-1-93)

012. CONTINUATION OF DESIGNATION OF A MANAGING GENERAL AGENT.

Designation of a MGA with the Idaho Department of Insurance shall continue in force and effect under the following conditions: (7-1-93)

01. Fees. On or before July 1 of each year the Department receives payment of the redesignation fee provided in IDAPA 18.01.02. (7-1-93)

02. Proof of Compliance with Bonding and Insurance Requirements. On or before July 1 of each year the Department is provided proof of continued compliance with the bonding and insurance requirements of Section 013. (7-1-93)

03. Additional Information. On or before July 1 of each year the Department is provided with amendments to the list of names and addresses of insurers doing business in the state of Idaho or Idaho domestic insurers with which the MGA has a contract and a verified statement on a form provided by the Department that the contract(s) contain the provisions required by Section 41-1504, Idaho Code. (7-1-93)

04. Continued Licensure. Continued licensure as an agent pursuant to the provisions of Chapter 10, Title 41, Idaho Code. (7-1-93)

013. SECURITY PAYMENTS.

01. Bond. All MGAs shall acquire a surety bond as defined in Subsection 044.02 for the protection of the insurer and insureds. The bond shall be in the amount of fifty thousand dollars (\$50,000) or ten percent (10%) of the amount of total funds handled within the preceding year, whichever is greater. The bond amount shall be adjusted accordingly on or before July 1 of each year. Coverage shall not be written by the insurer or an affiliate of the insurer employing the MGA. The bond shall be issued by a surety insurer admitted to conduct business in the state of Idaho. A copy of the executed bond shall be filed with the Department. (7-1-93)

02. Errors and Omissions Policy. All MGAs shall acquire and maintain an errors and omissions insurance policy as defined in Section 004. The policy coverage limit shall be set at two hundred and fifty thousand dollars (\$250,000) or twenty-five percent (25%) of the gross amount of direct written premiums received by an insurer for the previous calendar year that are attributable to the MGA, whichever is greater. The policy coverage limit shall be adjusted accordingly on or before July 1 of each year. Unless approved by the director, coverage shall not be written by the insurer or an affiliate of the insurer employing the MGA. Proof of insurance shall be filed with the Department. (7-1-93)

014. INDEPENDENT AUDIT OR EXAMINATION.

01. Annual Independent Audit of MGA. An independent audit by a certified public accountant shall be conducted annually for MGAs currently under contract, and shall be contracted for by the insurer. The independent audit shall include the following: (7-1-93)

- a. Report of independent certified public accountant; (7-1-93)
- b. Balance sheet; (7-1-93)
- c. Statement of income; (7-1-93)
- d. Statement of cash flow; (7-1-93)
- e. Statement of income and retained earnings; (7-1-93)
- f. Notes on financial statements - these notes shall be those required by General Accepted Accounting Principals; and (7-1-93)
- g. A copy of a management letter or a narrative statement setting forth what would have been the content of the management letter had such letter been completed. (7-1-93)

02. Retention of Report by Insurer. An insurer shall retain a current independent audit by a certified public accountant of each MGA with which the insurer has done business. (7-1-93)

03. Examination of MGA. The Department shall retain authority to examine a MGA notwithstanding the termination of the MGA's contractual authority. Pursuant to the provisions of Chapter 2, Title 41, Idaho Code, the expense of such examination shall be reimbursed to the Department by the insurer employing the MGA. (6-30-19)T

015. TERMINATION OF CONTRACT.

01. Notice to the Department. Within thirty (30) days of the termination of an agreement between a MGA and an Idaho domestic insurer or a foreign insurer for which the MGA was conducting business in the state of Idaho, the insurer must provide notice to the Department of the termination. Notice shall include: (7-1-93)

- a. The name of the person, firm, association or corporation acting as a MGA under the terms of the contract; and (7-1-93)
- b. The basis for the termination. (7-1-93)

02. Delivery of Records to Insurer upon Termination of Contract. If the contract between an insurer and a MGA is terminated for any reason, the MGA shall, upon request by the insurer, deliver all records to the insurer within ninety (90) days of the request. (7-1-93)

016. PENALTIES AND LIABILITIES:

01. Penalties for Violation of the MGA Act or This Chapter Rule. If the Director finds, after a hearing conducted in accordance with the Idaho Insurance Code and the Rules and Procedures adopted by the Department, that any person, firm, association or corporation has violated any of the provisions contained in the MGA Act or this rule chapter, the Director may, in addition to those items specified in 41-1507, Idaho Code, order revocation or suspension of the agent's license or the company's certificate of authority. (6-30-19)T

02. Other Penalties Not Affected. Nothing contained in this rule shall affect the right of the Director to impose any other penalties provided in the insurance statutes or regulations. (7-1-93)

03. Rights of Policyholders, Claimants and Auditors Not Limited. Nothing contained in this rule is intended to, or shall in any manner, limit or restrict the rights of policyholders, claimants and auditors. (7-1-93)

017. -- 999. (RESERVED)

**IDAPA 18
TITLE 06
CHAPTER 06**

18.06.06 – RULES FOR THE SURPLUS LINE REGULATION

000. LEGAL AUTHORITY.

The statutory authority of this rule is Title 67, Chapter 52, Idaho Code and Title 41, Chapters 2 and 12, Idaho Code. (1-1-94)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.06.06, "Rules for the Surplus Line Regulation." (6-30-19)T

02. Scope. The purpose of this rule is to provide procedures for the placement of surplus line insurance. (5-3-03)

002. WRITTEN INTERPRETATIONS.

The Department of Insurance has or relies upon written interpretive statements of the rule chapter in accordance with Section 67-5201(19)(b)(iv), Idaho Code. (1-1-94)

003. ADMINISTRATIVE APPEALS.

All administrative appeals shall be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, Idaho Rules of Administrative Procedure, Idaho Rules of Administrative Procedure of the Attorney General - General Provisions. (6-30-19)T

004. DEFINITIONS.

01. Open Lines for Export. The term "Open Lines for Export" shall mean the class or classes of business which the Director by order or by, rule, bulletin, or by publishing on the Department of Insurance website, has declared eligible for export in accordance with Section 41-1216, Idaho Code, and for which there appears to be no reasonable or adequate market among authorized insurers, either to acceptance of risk, contract terms, or premium or premium rate. (6-30-19)T

02. Lines Other Than Open Lines for Export. The term "Lines Other Than Open Lines for Export" shall mean the class of classes of business not on the list of open lines for export which are to be offered to eligible surplus lines insurers in accordance with Sections 41-1214, and 41-1215, Idaho Code. (6-30-19)T

03. Diligent Search. Diligent search or effort by the Surplus Line producer, for purposes of Section 41-1214(2), Idaho Code, shall be deemed to have been exercised if the Surplus Line producer or the referring insurance producer shall submit a risk to at least three authorized companies, which are engaged in writing in Idaho the type of coverage sought, or if there are no companies actually engaged in writing such coverage, the risk shall be submitted to at least three companies which, in the Surplus Line producer's or the insurance producer's professional judgment, are the most likely to accept the risk. (6-30-19)T

005. DELEGATION OF RESPONSIBILITY TO SURPLUS LINES ASSOCIATION.

The Idaho Department of Insurance delegates the following activities to the Surplus Lines Association of Idaho ("Association"): (6-30-19)T

01. Eligibility for Export. Under the general supervision of the Idaho Department of Insurance, the Association will be responsible for determination of eligibility for export of particular proposed coverages to eligible unauthorized insurers. (6-30-19)T

02. Broker Compliance. The Association is to examine all submissions from licensed resident and non-resident Idaho Surplus Lines Brokers to assure compliance with Section 41-1217, Idaho Code - Eligible Surplus Lines Insurers. (6-30-19)T

03. Requirements of Surplus Lines Association. That the Association, in addition to the

responsibilities outlined above, shall: (6-30-19)T

a. For the protection of all concerned have its Articles, By-Laws, Rules, and Procedures approved by the Director. Any changes made therein should receive prior approval before being put into effect. However, any submitted change, if not acted on within sixty (60) days of receipt by the Director, will be deemed approved. (6-30-19)T

b. File with the Director, and keep current, a list of its members. (6-30-19)T

c. Keep complete records of all transactions concerning Surplus Lines to the end that proper tax may be collected on surplus lines policies and that proper reports will be forwarded to the Director as concerns all submissions. Submissions are to be made by licensed Idaho Surplus Lines Brokers through the Association to the Director on forms approved by the Director, and shall comply with requirements of Chapter 12, Idaho Code. (6-30-19)T

d. Make its records available at any time for examination by the Director. (6-30-19)T

e. Report through its manager to the Director any known violations of the Surplus Lines Law as cited in Title 41, Chapter 12, Idaho Code. (6-30-19)T

006 -- 010. (RESERVED)

010. DELEGATION OF RESPONSIBILITY TO SURPLUS LINES ASSOCIATION.

The Idaho Department of Insurance delegates the following activities to the Surplus Lines Association of Idaho ("Association"): (6-30-19)T

01. Eligibility for Export. Under the general supervision of the Idaho Department of Insurance, the Association will be responsible for determination of eligibility for export of particular proposed coverages to eligible unauthorized insurers. (6-30-19)T

02. Broker Compliance. The Association is to examine all submissions from licensed resident and nonresident Idaho Surplus Lines Brokers to assure compliance with Section 41-1217, Idaho Code - ELIGIBLE SURPLUS LINES INSURERS. (6-30-19)T

03. Requirements of Surplus Lines Association. That the Association, in addition to the responsibilities outlined above, shall: (6-30-19)T

a. For the protection of all concerned have its Articles, By-Laws, Rules, and Procedures approved by the Director. Any changes made therein should receive prior approval before being put into effect. However, any submitted change, if not acted on within sixty (60) days of receipt by the Director, will be deemed approved. (6-30-19)T

b. File with the Director, and keep current, a list of its members. (6-30-19)T

c. Keep complete records of all transactions concerning Surplus Lines to the end that proper tax may be collected on surplus lines policies and that proper reports will be forwarded to the Director as concerns all submissions. Submissions are to be made by licensed Idaho Surplus Lines Brokers through the Association to the Director on forms approved by the Director, and shall comply with requirements of Chapter 12, Idaho Code. (6-30-19)T

011. BIENNIAL LICENSE.

The Idaho license of a resident or non-resident Surplus Line Broker must be renewed every two (2) years. Both the original license fee and the renewal fee are prescribed in the Rules of the Idaho Department of Insurance ("Department"), IDAPA 18.01.02, "Schedule of Fees, Licenses, and Miscellaneous Charges." Producers are in violation of the Insurance Code if they solicit surplus line business before they are licensed as a Surplus Line Broker. If a broker decides not to renew his license in any particular year, he should notify the Licensing Division of the Department of his intention prior to his license renewal date. The Director may, in his discretion, allow the

continuation of a license which is not timely renewed, if, within one (1) year after the renewal date, the licensee submits the appropriate renewal request and a continuation fee which is twice the amount otherwise required as provided by Section 41-1008(3), Idaho Code. (5-3-03)

012. ANNUAL REPORT.

Each Surplus Line Broker shall file an annual report with the Director by March 1st of each year, of Surplus Line business transacted during the previous calendar year on forms approved by the Director. (6-30-19)T

013. PAYMENT OF STATE TAX.

01. Tax Due March 1. On or before March 1st of each year, all Idaho licensed Surplus Line Brokers shall pay to the Department the premium tax on business written during the preceding calendar year. The Surplus Line Broker must collect this tax from the insured, in addition to the stamping fee. (5-3-03)

02. Tax Summary. By February 1st of each year the Surplus Lines Association will provide to each Surplus Line Broker a summary of records showing the state tax due the Department for the preceding year. The broker must pay to the Department the exact amount of tax indicated on the Surplus Lines Association summary. A flat percentage of the gross premium written during the year is not acceptable since tax was collected on each individual policy and that full amount must be paid to the Department. (5-3-03)

014. PAYMENT OF STAMPING FEES.

01. Application. The stamping fee shall be charged on all premiums and policy fees written on Idaho business at a rate established by the Board of Directors of the Surplus Line Association and approved by the Department. This rate will be adjusted from time to time in order to obtain the objectives of the Association. The stamping fee cannot be refunded except where there are extenuating circumstances, reported to, and approved by the Surplus Lines Association. (5-3-03)

02. Association Summary. Within ten (10) days following the month during which the surplus line insurance was handled through the Association office, the Manager will submit to each Surplus Line Broker an invoice summarizing the premium, Idaho tax, and Stamping Fee for each submission processed. (5-3-03)

03. Payable on Receipt. The Stamping Fee of the Surplus Line Association is payable upon receipt of billing. It is delinquent if not paid within thirty (30) days after the last day of the month in which the business was reported. (1-1-94)

015. COLLECTION OF TAXES.

01. Idaho Premium Taxes. Idaho Premium Tax must be collected from the insured. This tax is charged on the premium paid. Policy fees, service fees, and other like fees are considered part of the premium and subject to premium tax. State premium taxes must be refunded to the taxpayer upon cancellation of the policy or return of premium for any reason. (5-3-03)

02. Purchasing Groups. Purchasing groups that obtain insurance from an unauthorized or authorized surplus lines insurer must use a surplus lines broker licensed in the state of Idaho. The Surplus Lines Broker is responsible to collect and submit all taxes and fees to the Surplus Lines Association. (5-3-03)

016. REPORTING TAXES AND STAMPING FEES.

Brokers must report premium taxes and stamping fees in increments of not less than one year. If a broker elects to collect quarterly or monthly payments of premiums from the insured, he may do so, providing he reports the premium tax and stamping fee in the initial submission or renewal for a full year. (1-1-94)

017. PLACEMENT AND COMMISSIONS.

01. Basic Requirement. All surplus line business whether produced from within the state of Idaho or outside, must be placed through a licensed Surplus Line Broker. Each producer of surplus line business must hold a resident or non-resident producer license for Idaho. (5-3-03)

02. Idaho Producer. When a producer requests placement by a licensed Surplus Line Broker the commission received and paid shall be based on the mutual written agreement of the parties concerned. (6-30-19)T

018. SUBMISSION TIME PERIODS.

All affidavits, submissions, certificates, endorsements and other documents for insurance written for Open Lines for Export and Other Than Open Lines for Export must be received at the Surplus Lines Association within thirty (30) days of receipt by the broker of the certificate, endorsement or other policy document. If the complete submission cannot be made within this time period, then the information with submission form and affidavit, if applicable, will be forwarded. The broker is responsible for meeting this requirement and the burden of compliance is upon him. (6-30-19)T

019. OPEN LINES FOR EXPORT.

A list of approved classes of insurance coverage or risks shall be published by the Director and a copy of which shall be delivered to and maintained by a delegated association, if one has been delegated. These classes are recognized by the Department and the Association as eligible for export since it has been previously determined that an adequate market among authorized insurers does not exist in Idaho. Under this provision, brokers are not required to comply with sections 41-1214(2), (3) and 41-1215 of the Idaho Insurance Code, but proper submission must be provided to the Director or to a delegated association, if one has been delegated pursuant to Section 41-1232(c), Idaho Code, within thirty (30) days after the insurance policy is received by the Idaho broker. If a risk does not appear on this list, then the broker must file the normal submission forms and documents and he must execute the broker's affidavit. (6-30-19)T

020. BROKERS RECORDS.

Each broker shall keep in his office a full and true record of each surplus line coverage procured by him as outlined in section 41-1227 of the Idaho Insurance Code. Reports of all documents processed by the Surplus Lines Association will be provided on a monthly basis to the broker. These reports, in addition to the broker's copy of policies and endorsements, must be kept for a period of five (5) years and are subject to examination by the director. (5-3-03)

021. APPROVED LIST OF INSURERS.

A list, commonly known as the "white" list, containing the only non-admitted companies authorized to write surplus line business in this state will be issued from time to time by the Director. While this list is in effect, a broker may place surplus line business with those companies only. After receiving the updates from the Director, the association will keep brokers informed of additions and changes through timely notice. (7-1-98)

022. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 01**

**18.07.01 – RULES PERTAINING TO IDAHO ACQUISITIONS OF CONTROL
AND INSURANCE HOLDING COMPANY SYSTEMS**

000. LEGAL AUTHORITY.

These rules are promulgated by the Director of the Department of Insurance pursuant to the authority of sections 41-211 and 41-3817, Idaho Code. (3-20-14)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.07.01, “Rules Pertaining to Idaho Acquisitions of Control and Insurance Holding Company Systems.” (3-20-14)

02. Scope. The purposes of these rules are: To set forth rules and procedural requirements which the Director deems necessary to carry out the provisions of the Idaho Acquisitions of Control and Insurance Holding Company Systems Regulatory Act, Title 41, Chapter 38, Idaho Code, also hereinafter referred to as “the Act.” The information called for by these rules is hereby declared to be necessary and appropriate in the public interest and for the protection of policyholders and shareholders of this state. (3-20-14)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office of this agency. (7-1-99)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Title 41, Chapter 2, and Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-20-14)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (3-20-14)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-20-14)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-20-14)

03. Street Address. 700 West State Street, 3rd Floor, Boise, ID 83720-0043. (3-20-14)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (3-20-14)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho public records law within Title 74, Chapter 1, Idaho Code. (3-20-14)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Executive Officer. 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. (3-20-14)

02. Ultimate Controlling Person. That person who is not controlled by any other person. (3-20-14)

03. Section 41-3802, Idaho Code. Unless the context otherwise requires, other terms found in these rules and in Section 41-3802, Idaho Code, are used as defined therein. Other nomenclature or terminology is used as provided for in Title 41, Idaho Code, or industry usage if not defined therein. (3-20-14)

011. FORMS -- GENERAL REQUIREMENTS.

01. Forms Intended to Be Guides. Forms A, B, C, D, E, and F are intended to be guides in the preparation of statements required by Sections 41-3804, 41-3808, 41-3809 and 41-3810, Idaho Code. They are not intended to be blank forms which are to be filled in. The 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 occurring 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. (3-20-14)

02. Filings of Statement. Each statement, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Director electronically and at least one hard copy by personal delivery or mail. At least one (1) of the copies shall be 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. (3-20-14)

03. Format. Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. 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. (3-20-14)

04. Hearing. If an applicant requests a hearing on a consolidated basis under Section 41-3806(3), Idaho Code, in addition to filing the Form A with the Director, the applicant shall file a copy of Form A with the NAIC (National Association of Insurance Commissioners) in electronic form. (3-20-14)

012. FORMS -- INCORPORATION BY REFERENCE, SUMMARIES AND OMISSIONS.

01. Incorporation by Reference. Information required by any item of Form A, Form B, Form D, Form E, or Form F 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, Form E, or Form F 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 Director which were filed within three (3) 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. (3-20-14)

02. Summaries or Outlines. 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 Director which was filed within three (3) years and may be qualified in its entirety by such reference. In any case where two (2) 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 (1) 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. (3-20-14)

013. FORMS -- INFORMATION UNKNOWN OR UNAVAILABLE AND EXTENSION OF TIME TO FURNISH.

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there

shall be filed with the Director a separate document: (3-20-14)

01. Identification. Identifying the information, document or report in question; (3-20-14)

02. Impracticality. Stating why the filing thereof at the time required is impractical; and (3-20-14)

03. Extension. 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 Director within twenty-eight (28) days after receipt thereof enters an order denying the request. (3-20-14)

014. FORMS -- ADDITIONAL INFORMATION AND EXHIBITS.

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E, and Form F, the Director may request 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, E, or F 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. (3-20-14)

015. SUBSIDIARIES OF DOMESTIC INSURERS.

The authority to invest in subsidiaries under Section 41-3803, Idaho Code, is in addition to any authority to invest in subsidiaries which may be contained in any other provision of Title 41, Idaho Code. (3-20-14)

016. ACQUISITION OF CONTROL -- STATEMENT FILING.

A person required to file a statement pursuant to Section 41-3804, Idaho Code, shall furnish the required information on Form A, which is hereby made a part of this rule. Such person shall also furnish the required information on Form E, hereby made a part of this rule and described in Section 019. of this chapter. (3-20-14)

017. AMENDMENTS TO FORM A.

The applicant shall promptly advise the Director of any changes in the information furnished on Form A arising subsequent to the date upon which the information was furnished but prior to the Director's disposition of the application. (3-20-14)

018. ACQUISITION OF SECTION 41-3804(1)(D) INSURERS.

01. Name of the Domestic Insurer. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of Section 41-3804(1)(d), Idaho Code, the name of the domestic insurer on the cover page should be indicated as follows: "ABC Insurance Company, a subsidiary of XYZ Holding Company." (3-20-14)

02. References to Insurer. Where a Section 41-3804(1)(d) 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. (3-20-14)

019. PRE-ACQUISITION NOTIFICATION.

01. Pre-Acquisition Notification -- Domestic Insurer. If a domestic insurer, including any person controlling a domestic insurer, is proposing a merger or acquisition pursuant to Section 41-3802(1)(a), Idaho Code, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to Section 41-3808(3)(a), Idaho Code. (3-20-14)

02. Pre-Acquisition Notification - Non-Domiciliary Insurer. If a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to Section 41-3808, Idaho Code, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition form need be filed if the acquisition is beyond the scope of Section 41-3808, Idaho Code, as set forth in Section 41-3808(2), Idaho Code. (3-20-14)

03. Expert Opinion. In addition to the information required by Form E, the director may wish to require an expert opinion as to the competitive impact of the proposed acquisition. (7-1-99)

020. ANNUAL REGISTRATION OF INSURERS -- STATEMENT FILING.

An insurer required to file a statement pursuant to Section 41-3809, Idaho Code, shall furnish the required information on Form B, which is hereby made a part of these rules. (3-20-14)

021. SUMMARY OF REGISTRATION -- STATEMENT FILING.

An insurer required to file an annual registration statement pursuant to section 41-3809, Idaho Code, is also required to furnish information required on Form C, hereby made a part of these rules. (3-20-14)

022. AMENDMENTS TO FORM B.

01. Amendment to Form B. An amendment to Form B shall be filed within fifteen (15) days after the end of any month in which there is a material change to the information provided in the annual registration statement. (7-1-99)

02. Form B Format. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each 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. (7-1-99)

023. ALTERNATIVE AND CONSOLIDATED REGISTRATIONS.

01. Filing on Behalf of Affiliated Insurers. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 41-3809, Idaho Code. A registration statement may include information regarding any insurer in the insurance holding 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: (3-20-14)

a. The statement or report contains substantially similar information required to be furnished on Form B; and (12-24-93)

b. The filing insurer is the principal insurance company in the insurance holding company system. (3-20-14)

02. Statement That Filing Insurer Is the Principal Insurer. The question of whether the filing insurer is the principal insurance company in the insurance holding 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 simple statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding system. (12-24-93)

03. Unauthorized Insurer. With the prior approval of the Director, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under Subsection 023.01 of this rule. (3-20-14)

04. Consolidated Registration Statements. Any insurer may take advantage of the provisions of Section 41-3809(8), or 41-3809(9), Idaho Code, without obtaining prior approval of the Director. The Director, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good. (3-20-14)

024. DISCLAIMERS AND TERMINATION OF REGISTRATION.

01. Information Required. 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: (12-24-93)

a. The number of authorized, issued and outstanding voting securities of the subject; (12-24-93)

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 shares concerning which there is a right to acquire, directly or indirectly; (12-24-93)

c. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person: (12-24-93)

d. A statement explaining why such person should not be considered to control the subject. (12-24-93)

02. Request Deemed Granted. A request for termination of registration shall be deemed to have been granted unless the Director, within thirty (30) days after he receives the request, notifies the registrant otherwise. (12-24-93)

025. TRANSACTIONS SUBJECT TO PRIOR NOTICE - NOTICE FILING.

01. Form D. An insurer required to give notice of a proposed transaction pursuant to section 41-3810, Idaho Code, shall furnish the required information on Form D, set forth in Subsection 025.02. (3-20-14)

02. Agreements. Agreements for cost sharing services and management services shall at a minimum and as applicable: (3-20-14)

a. Identify the person providing services and the nature of such services; (3-20-14)

b. Set forth the methods to allocate costs; (3-20-14)

c. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual; (3-20-14)

d. Prohibit advancement of funds by the insurer to the affiliate except to pay for services specified in the agreement; (3-20-14)

e. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance; (3-20-14)

f. Define books and records of the insurer to include all books and records developed or maintained under or related to the agreement; (3-20-14)

g. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer; (3-20-14)

h. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer; (3-20-14)

i. Include standards for termination of the agreement with and without cause; (3-20-14)

j. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services; (3-20-14)

k. Specify that, if the insurer is placed in receivership or seized by the Director under Title 41, Chapter 33, Idaho Code: (3-20-14)

i. All of the rights of the insurer under the agreement extend to the Director; and (3-20-14)

ii. All books and records shall immediately be made available to the Director, and shall be turned over to the Director immediately upon the Director's request; (3-20-14)

i. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to Title 41, Chapter 33, Idaho Code; and (3-20-14)

m. Specify that the affiliate shall continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the Director under Title 41, Chapter 33, Idaho Code, and will make them available to the Director, for so long as the affiliate continues to receive timely payment for services rendered. (3-20-14)

026. ENTERPRISE RISK REPORT.

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 41-3809(12), Idaho Code, shall furnish the required information on Form F, located at the end of this chapter. (3-20-14)

027. EXTRAORDINARY DIVIDENDS AND OTHER DISTRIBUTIONS.

01. Request for Approval. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following: (3-20-14)

a. The amount of the proposed dividend; (12-24-93)

b. The date established for payment of the dividend; (12-24-93)

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; (12-24-93)

d. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information: (12-24-93)

i. The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of twelve (12) 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; (3-20-14)

ii. Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding; (12-24-93)

iii. If the insurer is a life insurer, the net gain from operations for the twelve (12) month period ending the 31st day of December next preceding; and (4-11-19)

iv. If the insurer is not a life insurer, the net income less net realized capital gains for the twelve (12) month period ending the 31st day of December next preceding. (4-11-19)

e. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Director and the end of the month preceding the month in which the request for dividend approval is submitted; and (3-20-14)

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. (12-24-93)

02. Other Dividends. Subject to Section 41-3812, Idaho Code, each registered insurer shall report to the Director all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsections 027.01.d. (3-20-14)

028. ADEQUACY OF SURPLUS.

The factors set forth in Section 41-3811, Idaho Code, are not intended to be an exhaustive list. In determining the adequacy and reasonableness of the insurer's surplus, no single factor is necessarily controlling. The Director,

instead, will consider the net effect of all of these factors, plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Director 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 Director will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant. (3-20-14)

029. -- 999. (RESERVED)

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 Idaho _____

Dated: _____, 20__

Name, title, address and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

ITEM 1. 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 (5) 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 interrelationships among the applicant and all affiliates of 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 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.

On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if he is an individual or (2) all persons who are directors, executive officers or owners of ten percent (10%) 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 employments during the last five (5) 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 (10) 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 must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS FOR INSURER.

Describe any plans or proposals which the applicant may have to declare as an extraordinary dividend, to liquidate the 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 persons 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 the 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 (12) calendar months preceding the filing of this statement. Include in the 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 (12) 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, exhibits, and three-year financial projections of the insurer(s) 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 (5) 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 the information is available. The statements may be prepared on either an individual basis, or, unless the Director otherwise requires, on a consolidated basis if 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 Sections 011 and 013.

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION.

Signature and certifications required as follows:

SIGNATURE

Pursuant to the requirements of Section 41-3804, Idaho Code, _____
as caused this application to be duly signed on its behalf
in the City of _____ and State of _____
on the _____ day _____ 20____.

Pursuant to the requirements of Section 41-3804, Idaho Code,
has caused this application to be duly signed on its behalf in the City of _____ and State of _____
on the _____ day _____ 20____.

(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 _____ 20____,
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 the 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) _____

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 20____, 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 the 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) _____

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Idaho

By

Name of Registrant

On behalf of the following insurance companies:

Name Address

Date: _____, 20 ____.

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. 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 control. As to each person specified in the 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 (10%) 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; and
- 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.

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, 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 (5) years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations.

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 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 and/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 41-3809, Idaho Code.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent (1%) or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Director, 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 the transaction; and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS.

Provide 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. If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, 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 Director otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Other than with respect to the foregoing, such financial statement shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Director. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

Unless the Director 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 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 that state.

Any ultimate controlling person who is an individual may file personal financial statements that have been reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the Personal Financial Statements Guide by the American Institute of Certified Public Accountants. Personal financial statements shall be accompanied by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

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 Sections 011 and 013 of these rules.

ITEM 9. FORM C REQUIRED.

A Form C, Summary of Changes to Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURES AND CERTIFICATION.

Signatures and certification of the form as follows:

SIGNATURE

Pursuant to the requirements of Section 41-3809, Idaho Code, the Registrant has caused this registration statement to be duly signed on its behalf in the City of _____ and the State of _____ on the day of _____, 20____.
(SEAL)

(Name of Registrant)

BY _____

(Name)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached registration statement dated _____ 20____, for and on behalf of _____;

(Name of Company)

that (s)he is the _____ of such,

(Name of Company)

company and that (s)he has authority to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument 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)

FORM C - SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of Idaho

By

Name of Registrant

On Behalf of Following Insurance Companies

Name _____ Address _____
Date: _____, _____ 20____

Name, Title, Address and telephone number of
Individual to Whom Notices and Correspondence
Concerning This Statement Should Be Addressed:

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Director, 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 (10%) 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 41-3809, Idaho Code, the Registrant has caused this summary of changes to registration statement to be duly signed on its behalf in the City of _____

and State of _____
on the _____ day of _____, 20____.

(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 changes to registration statement dated _____, 20____, 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)

FORM D - PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of Idaho

By

Name of Registrant

On Behalf of Following Insurance Companies

Name Address

Date: _____, _____ 20_____

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 non-affiliate, 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 41-3810(2)(a), (b), (c), (d), (e), (f) or (g), Idaho Code.

- b. A statement of the nature of the transaction.
- c. A statement of how the transaction meets the ‘fair and reasonable’ standard of section 41-3810(1)(a), Idaho Code.
- d. 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 non-life insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders or, (b) in the case of life insurers, three percent (3%) of the insurer’s admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE.

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets 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 non-life insurers, the lesser of three percent (3%) of the insurer’s admitted assets or twenty-five percent (25%) of surplus as regards policyholders or, with respect to life insurers, three percent (3%) 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 41-3810(2)(c)(ii), Idaho Code, or a reinsurance pooling agreement or modification thereto as described by section 41-3810(2)(c)(i), Idaho Code, furnish a description of the known and/or estimated amount of liability to be ceded and/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 non-affiliate 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 any of the next three (3) years, in connection with the reinsurance agreement or modification thereto is less than five percent (5%) of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding. Notice shall be given for all reinsurance pooling agreements including modifications thereto.

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.
- e. A brief statement as to the effect of the agreement upon the insurer's policyholder surplus.
- f. A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market." If market based, state the rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable.
- g. A statement regarding compliance with the NAIC Accounting Practices and Procedure Manual regarding expense allocation.

ITEM 7. SIGNATURE AND CERTIFICATION.

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 41-3810, Idaho Code,
has caused this notice to be duly signed on its behalf in
the City of _____ and State of _____
on the _____ day of _____, 20____.

(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 _____, 20 ____, for and on behalf of _____; that (s)he is the

(Name of Applicant)(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)

FORM E

**PRE-ACQUISITION NOTIFICATION FORM REGARDING THE POTENTIAL COMPETITIVE
IMPACT OF A PROPOSED MERGER OR ACQUISITION BY A NON-DOMICILIARY
INSURER DOING BUSINESS IN THIS STATE OR BY A DOMESTIC INSURER**

Name of Applicant

Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of Idaho

Dated: _____, 20 __

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 in each relevant insurance market 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. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in Section 41-3808(4), Idaho Code. If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.

For purposes of this question, market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

FORM F - ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of Idaho

By

Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name	Address
_____	_____
_____	_____
_____	_____

Date: _____, 20____

Name, Title, Address and telephone number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

ITEM 1. ENTERPRISE RISK.

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in Section 41-3802(3), Idaho Code, provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- a. Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system.
- b. Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system.
- c. Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities.
- d. Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system.
- e. Business plan of the insurance holding company system and summarized strategies for the next 12 months.
- f. Identification of material concerns of the insurance holding company system raised by a supervisory college, if any, in the last year.
- g. Identification of insurance holding company system capital resources and material distribution patterns.
- h. Identification of any negative movement, or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook).
- i. Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon.
- j. Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT.

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

**IDAPA 18
TITLE 07
CHAPTER 02**

**18.07.02 – RECOGNITION OF NEW ANNUITY MORTALITY TABLES FOR USE IN DETERMINING
RESERVE LIABILITIES FOR ANNUITIES AND PURE ENDOWMENT CONTRACTS**

000. LEGAL AUTHORITY.

The statutory authority for this rule is Title 67, Chapter 52, Idaho Code, and Idaho Code, Sections 41-211 and 41-612. (3-29-12)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.02, “Recognition of New Annuity Mortality Tables for Use in Determining Reserve Liabilities for Annuities and Pure Endowment Contracts.” (3-29-12)

02. Scope. The purpose of this rule is to recognize the following mortality tables for use in determining the minimum standard valuation for annuity and pure endowment contracts: the 1983 Table ‘a,’ the 1983 Group Annuity Mortality (1983 GAM) Table, the 1994 Group Annuity Reserving (1994 GAR) Table, the Annuity 2000 Mortality Table, and the 2012 Individual Annuity Reserve (2012 IAR) Table. (4-11-15)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of this rule, or to the documentation of compliance with this rule. These documents will be available for public inspection and copying in accordance with the Idaho Public Records Law, Title 74, Chapter 1, Idaho Code. (3-29-12)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-29-12)

004. INCORPORATION BY REFERENCE.

This rule incorporates by reference four (4) separate mortality tables. These mortality tables are: (3-29-12)

01. 1983 Table A. A table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and shown on page 708 of Volume 33 of the Transactions of Society of Actuaries 1981 and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners. <http://www.soa.org/library/research/transactions-of-society-of-actuaries/1981/january/tsa81v3325.pdf>, Page 708 (3-29-12)

02. 1983 GAM (Group Annuity Mortality) Table. A mortality table developed by the Society of Actuaries Committee on Annuities and shown on pages 880-881 of Volume 35 of the Transactions of Society of Actuaries 1983 and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners. <http://www.soa.org/library/research/transactions-of-society-of-actuaries/1983/january/tsa83v3527.pdf>, Pages 880 – 881 (3-29-12)

03. 1994 Group Annuity Reserving (GAR) Table. A mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume 47 of the Transactions of Society of Actuaries 1995. <http://www.soa.org/library/research/transactions-of-society-of-actuaries/1990-95/1995/january/tsa95v4722.pdf>, Pages 886 - 887 (3-29-12)

04. Annuity 2000 Mortality Table. The mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 266 of Volume 47 of the Transactions of Society of Actuaries 1995 – 96 Reports. <http://www.soa.org/library/research/transactions-reports-of-mortality-morbidity-and-experience/1990-99/1995/january/TSR9510.pdf>, Page 266 (3-29-12)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. **Office Hours.** 8 a.m. to 5 p.m. except weekends and legal holidays. (3-29-12)
02. **Mailing Address.** P.O. Box 83720, Boise, ID 83720-0043. (3-29-12)
03. **Street Address.** 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (3-29-12)
04. **Web Site Address.** The department’s web address is <http://www.doi.idaho.gov>. (3-29-12)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Law, Title 74, Chapter 1, Idaho Code. (3-29-12)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. **1983 Table ‘a’.** As used in this rule “1983 Table ‘a’” means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and shown on page 708 of Volume 33 of the Transactions of Society of Actuaries 1981 and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners. (3-29-12)

02. **1983 GAM Table.** As used in this rule “1983 GAM Table” means that mortality table developed by the Society of Actuaries Committee on Annuities and shown on pages 880-881 of Volume 35 of the Transactions of Society of Actuaries 1983 and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners. (3-29-12)

03. **1994 GAR Table.** As used in this rule “1994 GAR Table” means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume 47 of the Transactions of Society of Actuaries 1995. (3-29-12)

04. **2012 Individual Annuity Mortality Period Life (2012 IAM Period) Table.** As used in this rule, the “2012 Individual Annuity Mortality Period Life Table” or the “2012 IAM Period” means the Period table containing loaded mortality rates for calendar year 2012. This table contains rates, q_x^{2012} , developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices I and II. (4-11-15)

05. **2012 Individual Annuity Reserving (2012 IAR) Table.** As used in this rule, the “2012 Individual Annuity Reserving Table” or the “2012 IAR” means the generational mortality table developed by the Society of Actuaries Committee on Life Insurance Research and containing rates, q_x^{2012+n} derived from a combination of the 2012 IAM Period table and Projection Scale G2, using the methodology stated in Section 014. (4-11-15)

06. **Annuity 2000 Mortality Table.** As used in this rule “Annuity 2000 Mortality Table” means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 266 of Volume 47 of the Transactions of Society of Actuaries 1995 – 96 Reports. (3-29-12)

07. **Generational Mortality Table.** As used in this rule, “generational mortality table” means a mortality table containing a set of mortality rates that decrease for a given age from one year to the next based on a combination of a period table and a projection scale containing rates of mortality improvement. (4-11-15)

08. **Period Table.** As used in this rule, “period table” means a table of mortality rates applicable to a given calendar year (the Period). (4-11-15)

09. **Projection Scale G2 (Scale G2).** As used in this rule, “projection scale G2” is a table of annual rates, $G2_x$, of mortality improvement by age for projecting future mortality rates beyond calendar year 2012. This table was developed by the Society of Actuaries Committee on Life Insurance Research and is shown in Appendices 3 and 4. (4-11-15)

011. INDIVIDUAL ANNUITY OR PURE ENDOWMENT CONTRACTS.

01. Individual Annuity Mortality Table. Except as provided in Subsections 011.02 and 011.03, of this rule, the 1983 Table ‘a’ is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after July 1, 1982. (3-29-12)

02. Minimum Standard for Valuation. Except as provided in Subsection 011.03 of this rule, either the 1983 Table ‘a’ or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987. (3-29-12)

03. The Annuity 2000 Mortality Table. Except as provided in Subsection 011.04 of this rule, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after March 29, 2012. (4-11-15)

04. The 2012 IAR Mortality Table. Except as provided in Subsection 011.05 of this rule, the 2012 IAR Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2015. (4-11-15)

05. The 1983 Table ‘a.’ The 1983 Table ‘a’ without projection is to be used for determining the minimum standards of valuation for an individual annuity or pure endowment contract issued on or after March 29, 2012, solely when the contract is based on life contingencies and issued to fund periodic benefits arising from: (4-11-15)

a. Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions; (3-29-12)

b. Settlements involving similar actions such as workers’ compensation claims; or (3-29-12)

c. Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments. (3-29-12)

012. GROUP ANNUITY OR PURE ENDOWMENT CONTRACTS.

01. Group Annuity Mortality Tables. Except as provided in Subsections 012.02 and 012.03 of this rule, the 1983 GAM Table, the 1983 Table ‘a’ and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one (1) of these tables may be used for purposes of valuation for any annuity or pure endowment purchased on or after July 1, 1982, under a group annuity or pure endowment contract. (3-29-12)

02. Minimum Standard of Valuation. Except as provided in Subsection 012.03 of this rule, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987, under a group annuity or pure endowment contract. (3-29-12)

03. 1994 GAR Table. The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after the effective date of Subsection 012.03 under a group annuity or pure endowment contract. (3-29-12)

013. FORMULA.

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 specific in the 1994 GAR table. (3-29-12)

014. APPLICATION OF THE 2012 IAR MORTALITY TABLE.

01. Mortality Rate Formula. In using the 2012 IAR Mortality Table, the mortality rate for a person age x in year (2012 + n) is calculated as follows: (4-11-15)

a. $q_x^{2012+n} = q_x^{2012}(1 - G2_x)^n$ (4-11-15)

b. The resulting q_x^{2012+n} shall be rounded to three (3) decimal places per one thousand (1,000), e.g., 0.741 deaths per one thousand (1,000). The rounding shall occur according to the formula above, starting at the 2012 period table rate. (4-11-15)

02. Mortality Rate Formula Example. For a male age 30, $q_x^{2012} = 0.741$: (4-11-15)

a. $q_x^{2013} = 0.741 * (1 - 0.010)^1 = 0.73359$, which is rounded to 0.734. (4-11-15)

b. $q_x^{2014} = 0.741 * (1 - 0.010)^2 = 0.7262541$, which is rounded to 0.726. (4-11-15)

c. A method leading to incorrect rounding would be to calculate q_x^{2014} as $q_x^{2013} * (1 - 0.010)$, or $0.734 * 0.99 = 0.727$. It is incorrect to use the already rounded q_x^{2013} to calculate q_x^{2014} . (4-11-15)

015. SEVERABILITY.

If any provision of this rule or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby. (7-1-93)

016. -- 999. (RESERVED)

APPENDIX 1 2012 IAM Period Table Female, Age Nearest Birthday							
AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}
0	1.621	30	0.300	60	3.460	90	88.377
1	0.405	31	0.321	61	3.916	91	97.491
2	0.259	32	0.338	62	4.409	92	107.269
3	0.179	33	0.351	63	4.933	93	118.201
4	0.137	34	0.365	64	5.507	94	130.969
5	0.125	35	0.381	65	6.146	95	146.449
6	0.117	36	0.402	66	6.551	96	163.908
7	0.110	37	0.429	67	7.039	97	179.695
8	0.095	38	0.463	68	7.628	98	196.151
9	0.088	39	0.504	69	8.311	99	213.150
10	0.085	40	0.552	70	9.074	100	230.722
11	0.086	41	0.600	71	9.910	101	251.505
12	0.094	42	0.650	72	10.827	102	273.007
13	0.108	43	0.697	73	11.839	103	295.086
14	0.131	44	0.740	74	12.974	104	317.591
15	0.156	45	0.780	75	14.282	105	340.362
16	0.179	46	0.825	76	15.799	106	362.371
17	0.198	47	0.885	77	17.550	107	384.113

APPENDIX 1 2012 IAM Period Table Female, Age Nearest Birthday							
AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}
18	0.211	48	0.964	78	19.582	108	400.000
19	0.221	49	1.051	79	21.970	109	400.000
20	0.228	50	1.161	80	24.821	110	400.000
21	0.234	51	1.308	81	28.351	111	400.000
22	0.240	52	1.460	82	32.509	112	400.000
23	0.245	53	1.613	83	37.329	113	400.000
24	0.247	54	1.774	84	42.830	114	400.000
25	0.250	55	1.950	85	48.997	115	400.000
26	0.256	56	2.154	86	55.774	116	400.000
27	0.261	57	2.399	87	63.140	117	400.000
28	0.270	58	2.700	88	71.066	118	400.000
29	0.281	59	3.054	89	79.502	119	400.000
						120	1000.000

(4-11-15)

APPENDIX 2 2012 IAM Period Table Male, Age Nearest Birthday							
AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}
0	1.605	30	0.741	60	5.096	90	109.993
1	0.401	31	0.751	61	5.614	91	123.119
2	0.275	32	0.754	62	6.169	92	137.168
3	0.229	33	0.756	63	6.759	93	152.171
4	0.174	34	0.756	64	7.398	94	168.194
5	0.168	35	0.756	65	8.106	95	185.260
6	0.165	36	0.756	66	8.548	96	197.322
7	0.159	37	0.756	67	9.076	97	214.751
8	0.143	38	0.756	68	9.708	98	232.507
9	0.129	39	0.800	69	10.463	99	250.397
10	0.113	40	0.859	70	11.357	100	268.607
11	0.111	41	0.926	71	12.418	101	290.016
12	0.132	42	0.999	72	13.675	102	311.849
13	0.169	43	1.069	73	15.150	103	333.962
14	0.213	44	1.142	74	16.860	104	356.207
15	0.254	45	1.219	75	18.815	105	380.000
16	0.293	46	1.318	76	21.031	106	400.000
17	0.328	47	1.454	77	23.540	107	400.000
18	0.359	48	1.627	78	26.375	108	400.000

APPENDIX 2 2012 IAM Period Table Male, Age Nearest Birthday							
AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}	AGE	1000 - q_x^{2012}
19	0.387	49	1.829	79	29.572	109	400.000
20	0.414	50	2.057	80	33.234	110	400.000
21	0.443	51	2.302	81	37.533	111	400.000
22	0.473	52	2.545	82	42.261	112	400.000
23	0.513	53	2.779	83	47.441	113	400.000
24	0.554	54	3.011	84	53.233	114	400.000
25	0.602	55	3.254	85	59.855	115	400.000
26	0.655	56	3.529	86	67.514	116	400.000
27	0.688	57	3.845	87	76.340	117	400.000
28	0.710	58	4.213	88	86.388	118	400.000
29	0.727	59	4.631	89	97.634	119	400.000
						120	1000.000

(4-11-15)

APPENDIX 3 Projection Scale G2 Female, Age Nearest Birthday							
AGE	G2 _x	AGE	G2 _x	AGE	G2 _x	AGE	G2 _x
0	0.010	30	0.010	60	0.013	90	0.006
1	0.010	31	0.010	61	0.013	91	0.006
2	0.010	32	0.010	62	0.013	92	0.005
3	0.010	33	0.010	63	0.013	93	0.005
4	0.010	34	0.010	64	0.013	94	0.004
5	0.010	35	0.010	65	0.013	95	0.004
6	0.010	36	0.010	66	0.013	96	0.004
7	0.010	37	0.010	67	0.013	97	0.003
8	0.010	38	0.010	68	0.013	98	0.003
9	0.010	39	0.010	69	0.013	99	0.002
10	0.010	40	0.010	70	0.013	100	0.002
11	0.010	41	0.010	71	0.013	101	0.002
12	0.010	42	0.010	72	0.013	102	0.001
13	0.010	43	0.010	73	0.013	103	0.001
14	0.010	44	0.010	74	0.013	104	0.000
15	0.010	45	0.010	75	0.013	105	0.000
16	0.010	46	0.010	76	0.013	106	0.000
17	0.010	47	0.010	77	0.013	107	0.000
18	0.010	48	0.010	78	0.013	108	0.000
19	0.010	49	0.010	79	0.013	109	0.000

APPENDIX 3 Projection Scale G2 Female, Age Nearest Birthday							
AGE	G2_x	AGE	G2_x	AGE	G2_x	AGE	G2_x
20	0.010	50	0.010	80	0.013	110	0.000
21	0.010	51	0.010	81	0.012	111	0.000
22	0.010	52	0.011	82	0.012	112	0.000
23	0.010	53	0.011	83	0.011	113	0.000
24	0.010	54	0.011	84	0.010	114	0.000
25	0.010	55	0.012	85	0.010	115	0.000
26	0.010	56	0.012	86	0.009	116	0.000
27	0.010	57	0.012	87	0.008	117	0.000
28	0.010	58	0.012	88	0.007	118	0.000
29	0.010	59	0.013	89	0.007	119	0.000
						120	0.000

(4-11-15)

APPENDIX 4 Projection Scale G2 Male, Age Nearest Birthday							
AGE	G2_x	AGE	G2_x	AGE	G2_x	AGE	G2_x
0	0.010	30	0.010	60	0.015	90	0.007
1	0.010	31	0.010	61	0.015	91	0.007
2	0.010	32	0.010	62	0.015	92	0.006
3	0.010	33	0.010	63	0.015	93	0.005
4	0.010	34	0.010	64	0.015	94	0.005
5	0.010	35	0.010	65	0.015	95	0.004
6	0.010	36	0.010	66	0.015	96	0.004
7	0.010	37	0.010	67	0.015	97	0.003
8	0.010	38	0.010	68	0.015	98	0.003
9	0.010	39	0.010	69	0.015	99	0.002
10	0.010	40	0.010	70	0.015	100	0.002
11	0.010	41	0.010	71	0.015	101	0.002
12	0.010	42	0.010	72	0.015	102	0.001
13	0.010	43	0.010	73	0.015	103	0.001
14	0.010	44	0.010	74	0.015	104	0.000
15	0.010	45	0.010	75	0.015	105	0.000
16	0.010	46	0.010	76	0.015	106	0.000
17	0.010	47	0.010	77	0.015	107	0.000
18	0.010	48	0.010	78	0.015	108	0.000
19	0.010	49	0.010	79	0.015	109	0.000
20	0.010	50	0.010	80	0.015	110	0.000

APPENDIX 4 Projection Scale G2 Male, Age Nearest Birthday							
AGE	G2_x	AGE	G2_x	AGE	G2_x	AGE	G2_x
21	0.010	51	0.011	81	0.014	111	0.000
22	0.010	52	0.011	82	0.013	112	0.000
23	0.010	53	0.012	83	0.013	113	0.000
24	0.010	54	0.012	84	0.012	114	0.000
25	0.010	55	0.013	85	0.011	115	0.000
26	0.010	56	0.013	86	0.010	116	0.000
27	0.010	57	0.014	87	0.009	117	0.000
28	0.010	58	0.014	88	0.009	118	0.000
29	0.010	59	0.015	89	0.008	119	0.000
						120	0.000

(4-11-15)

**IDAPA 18
TITLE 07
CHAPTER 03**

**18.07.03 – VALUATION OF LIFE INSURANCE POLICIES INCLUDING THE INTRODUCTION
AND USE OF NEW SELECT MORTALITY FACTORS**

000. LEGAL AUTHORITY.

The statutory authority for this chapter is Title 67, Chapter 52, Idaho Code, and Idaho Code, Sections 41-211 and 41-612. (3-30-01)

001. TITLE AND SCOPE.

01. Title. This chapter is titled IDAPA 18.07.03, “Valuation of Life Insurance Policies Including the Introduction and Use of New Select Mortality Factors.” (3-30-01)

02. Scope. The purpose of this chapter is to provide: (3-30-01)

- a.** Tables of select mortality factors and rules for their use; (3-30-01)
- b.** Rules concerning a minimum standard for the valuation of plans with nonlevel premiums or benefits; and (3-30-01)
- c.** Rules concerning a minimum standard for the valuation of plans with secondary guarantees. (3-30-01)

03. Method. The method for calculating basic reserves defined in this chapter will constitute the commissioners’ reserve valuation method for policies to which this chapter is applicable. (3-30-01)

04. Applicability. This chapter applies to all life insurance policies, with or without nonforfeiture values, issued on or after the effective date of this chapter, subject to the following exceptions and conditions. (3-30-01)

- a.** Exceptions: (3-30-01)
 - i.** This chapter does not apply to any individual life insurance policy issued on or after the effective date of this chapter 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 effective date of this chapter, that guarantees the premium rates of the new policy. This chapter 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. (3-30-01)
 - ii.** This chapter does not apply to any universal life policy that meets all the following requirements: (3-30-01)
 - (1) Secondary guarantee period, if any, is five (5) years or less; (3-30-01)
 - (2) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the CSO valuation tables as defined in Subsection 010.06 and the applicable valuation interest rate; and (4-7-11)
 - (3) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period. (3-30-01)
 - iii.** This chapter does 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. (3-30-01)

iv. This chapter does 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. (3-30-01)

v. This chapter does 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 (1) year. (3-30-01)

b. Conditions: (3-30-01)

i. Calculation of the minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, will be in accordance with the provisions of Section 012. (4-7-11)

ii. 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 will be in accordance with the provisions of Section 013. (4-7-11)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (4-7-11)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General -- General Provisions." (4-7-11)

004. INCORPORATION BY REFERENCE.

The tables of select mortality factors are hereby incorporated by reference into IDAPA 18.07.03, "Valuation of Life Insurance Policies Including the Introduction and Use of the New Select Mortality Factors" that are the bases to which the respective percentage of Subsections 011.01.b., 011.02.b., and 011.02.c. are applied. The tables referenced are located on the Internet (website at <http://www.doi.idaho.gov> - select Rates and Policy Forms under the Companies link, see Related Rules and Bulletins - see Attachments to IDAPA 18.07.03). (4-7-11)

01. Types of Tables. The six (6) tables of select mortality factors incorporated herein by reference include: (3-30-01)

a. Male aggregate; (3-30-01)

b. Male nonsmoker; (3-30-01)

c. Male smoker; (3-30-01)

d. Female aggregate; (3-30-01)

e. Female nonsmoker; and (3-30-01)

f. Female smoker. (3-30-01)

02. Age Basis. These tables apply to both age last birthday and age nearest birthday mortality tables. (3-30-01)

03. Computation for Sex-Blended Mortality Tables. For sex-blended mortality tables, compute select mortality factors in the same proportion as the underlying mortality. For example, for the 1980 CSO-B Table, the calculated select mortality factors are eighty percent (80%) of the appropriate male table as referenced in Section

- Formulas -

$$G_t = \frac{GP_{x+k+t}}{GP_{x+k+t-1}}$$

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 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 (1%) in any policy year, at the company's option, but R_t shall not be less than one (1);

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 Paragraph 011.02.b. if Paragraph 011.02.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.

(4-7-11)

03. Deficiency Reserves. Excess, if greater than zero (0), of (3-30-01)

a. Minimum reserves calculated in accordance with Section 41-612(10), Idaho Code, over (3-30-01)

b. Basic reserves. (3-30-01)

04. Guaranteed Gross Premiums. Premiums under a policy of life insurance that are guaranteed and determined at issue. (3-30-01)

05. Maximum Valuation Interest Rates. Interest rates defined in Section 41-612(4b), Idaho Code (Computation of Minimum Standard by Calendar Year of Issue) that are to be used in determining the minimum standard for the valuation of life insurance policies. (3-30-01)

06. 1980 CSO Valuation Tables. Commissioners' 1980 Standard Ordinary Mortality Table (1980 CSO Table) without ten (10) year selection factors, incorporated into the 1980 amendments to the NAIC 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. (3-30-01)

07. Scheduled Gross Premium. Smallest illustrated gross premium at issue for other than universal

(1) 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 (1) 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 (19) year premium whole life plan of insurance of the same renewal year equivalent level amount at an age one (1) year higher than the age at issue of the policy. (3-30-01)

(2) A net one (1) year term premium for the benefits provided for in the first policy year. (3-30-01)

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. (3-30-01)

12. Universal Life Insurance Policy. 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. (3-30-01)

011. GENERAL CALCULATION REQUIREMENTS FOR BASIC RESERVES AND PREMIUM DEFICIENCY RESERVES.

01. Basic Reserves. At the election of the company for any one (1) or more specified plans of life insurance, the minimum mortality standard for basic reserves may be calculated using the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this chapter and promulgated by rule by the Director for this purpose). If select mortality factors are elected, they may be: (3-30-01)

a. The ten (10) year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; (3-30-01)

b. The select mortality factors in the tables as referenced in Section 004; or (4-7-11)

c. Any other table of select mortality factors adopted by the NAIC after the effective date of this chapter and promulgated by rule by the Director for the purpose of calculating basic reserves. (3-30-01)

02. Deficiency Reserves. Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero (0), of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the company for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after the effective date of this chapter and promulgated by rule by the Director). If select mortality factors are elected, they may be one of the following: (3-30-01)

a. The ten (10) year select mortality factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law; (3-30-01)

b. The select mortality factors in the tables as referenced in Section 004; (4-7-11)

c. For durations in the first segment, X percent of the select mortality factors in the tables as referenced in Section 004, subject to the following: (4-7-11)

i. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience; (3-30-01)

ii. X is such that, when using the valuation interest rate used for basic reserves, Item one (1) is greater than or equal to Item two (2); (3-30-01)

(1) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X; (3-30-01)

(2) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date; (3-30-01)

iii. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of mortality improvement beyond the valuation date, in each of the first five (5) years after the valuation date; (3-30-01)

iv. The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of Paragraph 011.02.c.; (4-7-11)

v. The appointed actuary may decrease X at any valuation date as long as X continues to meet all the requirements of Paragraph 011.02.c.; and (4-7-11)

vi. 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. (3-30-01)

vii. If X is less than one hundred percent (100%) at any duration for any policy, the following requirements shall be met: (3-30-01)

(1) The appointed actuary shall annually prepare an actuarial opinion and memorandum for the company in conformance with the requirements of the Actuarial and Memorandum Rule, IDAPA 18.07.10, Section 022, "Statement of Actuarial Opinion Based on an Asset Adequacy Analysis"; (4-7-11)

(2) The appointed actuary shall disclose, in the Regulatory Asset Adequacy Issues Summary, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one (1) or more interim periods; and (4-7-11)

(3) The appointed actuary shall annually opine for all policies subject to this chapter as to whether the mortality rates resulting from the application of X meet the requirements of Paragraph 011.02.c. 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. (4-7-11)

d. Any other table of select mortality factors adopted by the NAIC after the effective date of this chapter and promulgated by rule by the Director for the purpose of calculating deficiency reserves. (3-30-01)

03. Applicability. Subsection 011.03 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 (10) years, the appropriate ten (10) 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. (4-7-11)

04. Gross Premiums. In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves. (3-30-01)

05. Changes in Guarantees. Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one (1) year after the date of the change shall be the greatest of the following: (3-30-01)

a. Reserves calculated ignoring the guarantee; (3-30-01)

- b. Reserves assuming the guarantee was made at issue; and (3-30-01)
- c. Reserves assuming that the policy was issued on the date of the guarantee. (3-30-01)

06. Reserve Adequacy. The Director 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 effective date of this chapter. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of the Actuarial and Memorandum Rule, IDAPA 18.07.10, Section 022, "Statement of Actuarial Opinion Based on an Asset Adequacy Analysis." (4-7-11)

012. CALCULATION OF MINIMUM VALUATION STANDARD FOR POLICIES WITH GUARANTEED NONLEVEL GROSS PREMIUMS OR GUARANTEED NONLEVEL BENEFITS (OTHER THAN UNIVERSAL LIFE POLICIES).

01. Basic Reserves. 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 selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described below may be made: (3-30-01)

a. Treat the unitary reserve, if greater than zero (0), applicable at the end of each segment as a pure endowment and subtract the unitary reserve, if greater than zero (0), applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment; or (3-30-01)

b. Treat the guaranteed cash surrender value, if greater than zero (0), applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero (0), applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment. (3-30-01)

02. Deficiency Reserves. (3-30-01)

a. The deficiency reserve at any duration shall be calculated: (3-30-01)

- i. On a unitary basis if the corresponding basic reserve determined by Subsection 012.01 is unitary; (4-7-11)
- ii. On a segmented basis if the corresponding basic reserve determined by Subsection 012.01 is segmented; or (4-7-11)
- iii. On the segmented basis if the corresponding basic reserve determined by Subsection 012.01 is equal to both the segmented reserve and the unitary reserve. (4-7-11)

b. Subsection 012.02 shall apply to any policy for which the guaranteed 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 Subsection 011.02 and rate of interest). (4-7-11)

c. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero (0), for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in Subsection 011.02. (4-7-11)

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. (3-30-01)

03. Minimum Value. 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 mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the ten (10) year select factors incorporated into the 1980 amendments of 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 policyowner 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. (3-30-01)

04. Unusual Pattern of Guaranteed Cash Surrender Values. (3-30-01)

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. (3-30-01)

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: (3-30-01)

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: (3-30-01)

(1) The date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or (3-30-01)

(2) The mandatory expiration date of the policy; and (3-30-01)

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 (3-30-01)

iii. The net to gross ratio is equal to Item One (1) divided by Item Two (2) as follows: (3-30-01)

(1) 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. (3-30-01)

(2) The present value, at the beginning of the n year period, of the scheduled gross premiums payable during the n year period. (3-30-01)

c. For purposes of Subsection 012.04, 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: (4-7-11)

i. One hundred ten percent (110%) of the scheduled gross premium for that year; (3-30-01)

ii. One hundred ten percent (110%) of one (1) 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 (3-30-01)

iii. Five percent (5%) of the first policy year surrender charge, if any. (3-30-01)

05. Optional Exemption for Yearly Renewable Term (YRT) Reinsurance. At the option of the company, the following approach for reserves on YRT reinsurance may be used: (3-30-01)

- a.** Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year; (3-30-01)
- b.** Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 012.03; (4-7-11)
- c.** Deficiency reserves. (3-30-01)

 - i.** For each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium. (3-30-01)
 - ii.** 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 Subparagraph 012.05.c.i.; (4-7-11)
- d.** For purposes of Subsection 012.05, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten (10) year select mortality factors, or any other table adopted after the effective date of this chapter by the NAIC and promulgated by rule by the Director for this purpose; (4-7-11)
- e.** A reinsurance agreement shall be considered YRT reinsurance for purposes of Subsection 012.05 if only the mortality risk is reinsured; and (4-7-11)
- f.** 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. (3-30-01)

06. Optional Exemption for Attained-Age-Based Yearly Renewable Term Life Insurance Policies.
At the option of the company, the following approach for reserves for attained-age-based YRT life insurance policies may be used: (3-30-01)

- a.** Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year. (3-30-01)
- b.** Basic reserves shall never be less than the tabular cost of insurance for the appropriate period, as defined in Subsection 012.03. (4-7-11)
- c.** Deficiency reserves: (3-30-01)

 - i.** For each policy year, calculate the excess, if greater than zero (0), of the valuation net premium over the respective maximum guaranteed gross premium. (3-30-01)
 - ii.** 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 Subparagraph 012.06.c.i. (4-7-11)
- d.** For purposes of Subsection 012.06, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten (10) year select mortality factors, or any other table adopted after the effective date of this chapter by the NAIC and promulgated by rule by the Director for this purpose. (4-7-11)
- e.** A policy shall be considered an attained-age-based YRT life insurance policy for purposes of Subsection 012.06 if: (4-7-11)

 - 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 (3-30-01)
 - 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. (3-30-01)

f. For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of Subsection 012.06 may be used after the initial period if: (4-7-11)

i. The initial period is constant for all insureds of the same sex, risk class and plan of insurance; or (3-30-01)

ii. The initial period runs to a common attained age for all insureds of the same sex, risk class, and plan of insurance; and (3-30-01)

iii. After the initial period of coverage, the policy meets the conditions of Paragraph 012.06.e.; and (4-7-11)

g. If this election is made, this approach shall be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this chapter. (3-30-01)

07. Exemption from Unitary Reserves for Certain n-Year Renewable Term Life Insurance Policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the following conditions are met: (3-30-01)

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 (10) 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; (3-30-01)

b. The guaranteed gross premiums in all n -year periods are not less than the corresponding net premiums based upon the 1980 CSO Table with or without the ten (10) year select mortality factors; and (3-30-01)

c. There are no cash surrender values in any policy year. (3-30-01)

08. Exemption From Unitary Reserves for Certain Juvenile Policies. 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: (3-30-01)

a. At issue, the insured is age twenty-four (24) or younger; (3-30-01)

b. Until the insured reaches the end of the juvenile period, which shall occur at or before age twenty-five (25), the gross premiums and death benefits are level, and there are no cash surrender values; and (3-30-01)

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. (3-30-01)

013. 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.

01. General. The following general provisions apply. (3-30-01)

a. Policies with a secondary guarantee include: (3-30-01)

i. A policy with a guarantee that the policy will remain in force at the original schedule of benefits, subject only to the payment of specified premiums; (3-30-01)

ii. A policy in which the minimum premium at any duration is less than the corresponding one (1)

year valuation premium, calculated using the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten (10) year select mortality factors, or any other table adopted after the effective date of this chapter by the NAIC and promulgated by rule by the Director for this purpose; or (3-30-01)

iii. A policy with any combination of Subparagraphs 013.01.a.i. and 013.01.a.ii. (4-7-11)

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 013.02 and 013.03 below shall be recalculated from issue to reflect these changes. (4-7-11)

c. Specified premiums mean the premiums specified in the policy, 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. (3-30-01)

d. For purposes of Section 013, the minimum premium for any policy year is the premium that, when paid into a policy with a zero (0) account value at the beginning of the policy year, produces a zero (0) 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. (4-7-11)

e. The one (1) year valuation premium means the net one (1) year premium based upon the original schedule of benefits for a given policy year. The one (1) year valuation premiums for all policy years are calculated at issue. The select mortality factors defined in Paragraphs 011.02.b., 011.02.c., and 011.02.d. may not be used to calculate the one (1) year valuation premiums. (4-7-11)

f. The one (1) 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. (3-30-01)

02. Basic Reserves for the Secondary Guarantees. 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 Subsection 010.02. (4-7-11)

03. Deficiency Reserves for the Secondary Guarantees. Deficiency reserves, if any, for the secondary guarantees shall be calculated for the secondary guarantee period in the same manner as described in Subsection 012.02 with gross premiums set equal to the specified premiums, if any, or otherwise to the minimum premiums that keep the policy in force. (4-7-11)

04. Minimum Reserves. The minimum reserves during the secondary guarantee period are the greater of: (3-30-01)

a. The basic reserves for the secondary guarantee plus the deficiency reserve, if any, for the secondary guarantees; or (3-30-01)

b. The minimum reserves required by other rules or rules governing universal life plans. (3-30-01)

014. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 04**

18.07.04 – ANNUAL FINANCIAL REPORTING

000. LEGAL AUTHORITY.

This rule is promulgated by the Director of Insurance pursuant to the authority provided in Chapter 2, Title 41, Idaho Code and Chapter 52, Title 67, Idaho Code. (7-1-93)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.04, “Annual Financial Reporting.” (5-8-09)

02. Scope. The purpose of this rule is to improve the Idaho Insurance Department’s surveillance of the financial condition of insurers by requiring: (1) an annual audit of the financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants; (2) Communication of Internal Control Related Matters Noted in an Audit; and (3) Management’s Report of Internal Control over Financial Reporting. Every insurer as defined in Section 010 is subject to this rule. Insurers having direct premiums written in this state of less than one million dollars (\$1,000,000) in any calendar year and less than one thousand (1,000) policyholders or certificate holders of direct written policies nationwide at the end of such calendar year are exempt from this rule for such year (unless the director makes a specific finding that compliance is necessary for the director to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts or treaties of reinsurance of one million dollars (\$1,000,000) or more, or both, will not be so exempt. Foreign or alien insurers filing the audited financial report in another state, pursuant to that other state’s requirement for filing of audited financial reports which has been found by the director to be substantially similar to the requirements herein, are exempt from Section 011 through Section 020 of this rule if conditions of Subsection 001.02.a. or 001.02.b., of this rule apply: (5-8-09)

a. A copy of the Audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant’s Letter of Qualifications that are filed with the other state are filed with the director in accordance with the filing dates specified in Sections 011, 018, and 019 respectively (Canadian insurers may submit accountants’ reports as filed with the Office of the Superintendent of Financial Institutions, Canada). (5-8-09)

b. A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the director within the time specified in Section 017. This rule does not prohibit, preclude or in any way limit the director of Insurance from ordering, conducting or performing examinations of insurers pursuant to the provisions of Title 41 of the Idaho Code and the rules of the Idaho Department of Insurance and the practices and procedures of the Idaho Department of Insurance. (5-8-09)

c. Foreign or alien insurers required to file Management’s Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the director of the other state within the time specified. (5-8-09)

d. This rule shall not prohibit, preclude or in any way limit the director of Insurance from ordering, conducting or performing examinations of insurers pursuant to the provisions of Title 41 of the Idaho Code and the rules of the Idaho Department of Insurance and the practices and procedures of the Idaho Department of Insurance. (5-8-09)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of this rule, or to the documentation of compliance with this rule. These documents will be available for public inspection and copying in accordance with the public records act. (5-8-09)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative

Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General - General Provisions.” (5-8-09)

004. INCORPORATION BY REFERENCE.

This rule incorporates by reference the full text of the National Association of Insurance Commissioners Financial Condition Examiners Handbook and the National Association of Insurance Commissioners Annual Statement Instructions and Accounting Practices and Procedures Manual, pursuant to Sections 41-223 and 47-335, Idaho Code. Copies may be viewed at: (5-8-09)

01. Department. Idaho Department of Insurance, 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043; (5-8-09)

02. Industry Documents. NAIC Executive Headquarters, 2301 McGee Street, Suite 800 Kansas City, MO 64108-2662. NAIC website at http://www.naic.org/store_pub_accounting_reporting.htm#listing_of_cos. (5-8-09)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS AND WEB SITE.

01. Office Hours. The Department of Insurance is open from 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (5-8-09)

02. Mailing Address. The department’s mailing address is: Idaho Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. (5-8-09)

03. Street Address. The principal place of business is 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (5-8-09)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (5-8-09)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (5-8-09)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Accountant and Independent Certified Public Accountant. “Accountant” or “Independent Certified Public Accountant” means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants [AICPA] and in all states in which they are licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant. (5-8-09)

02. Affiliate. An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. (5-8-09)

03. Audit Committee. “Audit committee” means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or Group of insurers, and audits of financial statements of the insurer or Group of insurers. The Audit committee of any entity that controls a Group of insurers may be deemed to be the Audit committee for one (1) or more of these controlled insurers solely for the purposes of this rule at the election of the controlling person. Refer to Subsection 021.05 of this rule, for exercising this election. If an Audit committee is not designated by the insurer, the insurer’s entire board of directors shall constitute the Audit committee. (5-8-09)

04. Audited Financial Report. “Audited financial report” means and includes those items specified in Section 012 of this rule. (5-8-09)

05. Indemnification. “Indemnification” means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing or other misrepresentations made by the insurer or its representatives. (5-8-09)

06. Independent Board Member. “Independent board member” has the same meaning as described in Subsection 021.03 of this rule. (5-8-09)

07. Insurer. “Insurer” means a licensed insurer as defined in Section 41-110, Idaho Code; hospital and professional service corporation as defined in Chapter 34, Title 41, Idaho Code; hospital liability trust as defined in Chapter 37, Title 41, Idaho Code; managed care organization as defined in Chapter 39, Title 41, Idaho Code; self-funded health care plan as defined in Chapter 40, Title 41, Idaho Code; Joint Public Agency Self-Funded Health Care Plan as defined in Title 41, Chapter 41, Idaho Code; county mutual as defined in Title 41, Chapter 31, Idaho Code; reciprocal insurer as defined in Chapter 29, Title 41, Idaho Code; fraternal benefit society as defined in Chapter 31, Title 41, Idaho Code; and authorized/accredited reinsurer as defined in Section 41-514(b), Idaho Code. (5-8-09)

08. Group of Insurers. “Group of insurers” means those licensed insurers included in the reporting requirements of Title 41, Chapter 38, Idaho Code, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting. (5-8-09)

09. Internal Control over Financial Reporting. “Internal control over financial reporting” means a process effected by an entity’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, such as those items specified in Subsections 012.02 through 012.07 of this rule, and includes those policies and procedures that: (5-8-09)

a. Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets; (5-8-09)

b. Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, such as those items specified in Subsections 012.02 through 012.07 of this rule, and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and (5-8-09)

c. Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, such as those items specified in Subsections 012.02 through 012.07 of this rule. (5-8-09)

10. SEC. “SEC” means the United States Securities and Exchange Commission. (5-8-09)

11. Section 404. “Section 404” means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC’s rules and regulations promulgated thereunder. (5-8-09)

12. Section 404 Report. “Section 404 Report” means management’s report on “internal control over financial reporting” as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3A. (5-8-09)

13. SOX Compliant Entity. “SOX Compliant Entity” means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (5-8-09)

a. The preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (5-8-09)

b. The Audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (5-8-09)

c. The Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K). (5-8-09)

011. GENERAL REQUIREMENTS RELATED TO FILING AND EXTENSIONS FOR FILING OF ANNUAL AUDITED FINANCIAL REPORTS AND AUDIT COMMITTEE APPOINTMENT.

01. Annual Audit Filing Date. All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the director on or before June 1 for the year ended December 31 immediately preceding. The director may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer. (5-8-09)

02. Request for Extension. Extensions of the June 1 filing date may be granted by the director for thirty (30) day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting such extension and determination by the director of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the director to make an informed decision with respect to the requested extension. (5-8-09)

03. Management's Report of Internal Control over Financial Reporting. If an extension is granted in accordance with the provisions in Subsection 011.02 of this rule, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting. (5-8-09)

04. Designation of Audit Committee. Every insurer required to file an annual audited financial report pursuant to this chapter shall designate a group of individuals as constituting its Audit committee, as defined in Section 010. The Audit committee of an entity that controls an insurer may be deemed to be the insurer's Audit committee for purposes of this rule at the election of the controlling person. (5-8-09)

012. CONTENTS OF ANNUAL AUDITED FINANCIAL REPORT.

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 Department of Insurance of the state of domicile. The annual Audited financial report shall include the following: (5-8-09)

01. Report of Independent Certified Public Accountant. Report of independent certified public accountant; (5-8-09)

02. Balance Sheet. Balance sheet reporting admitted assets, liabilities, capital and surplus; (7-1-93)

03. Statement of Operations. Statement of operations; (7-1-93)

04. Statement of Cash Flow. Statement of cash flow; (5-8-09)

05. Statement of Changes in Capital and Surplus. Statement of changes in capital and surplus; (7-1-93)

06. 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 Section 41-335, Idaho Code, or other applicable section of Idaho Code with a written description of the nature of these differences. (5-8-09)

07. Form of Financial Statements. 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 director, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding 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.) (5-8-09)

013. DESIGNATION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

01. Registration with the Director. Each insurer required by this rule to file an annual audited financial report must within sixty (60) days after becoming subject to the requirement, register with the director in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this rule. Insurers not retaining an independent certified public accountant on the effective date of this rule shall register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed. (5-8-09)

02. Letter of Awareness. The insurer shall obtain a letter from the accountant, and file a copy with the director stating that the accountant is aware of the provisions of the Insurance Code and the Rules of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that he will express his opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Department, specifying such exceptions as he may believe appropriate. (5-8-09)

03. Dismissal or Resignation. If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the Department of this event. The insurer shall also furnish the director with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) 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 rule 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, such as 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 the 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 which he does not agree; and the insurer shall furnish such responsive letter from the former accountant to the director together with its own. (5-8-09)

014. QUALIFICATIONS OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

01. In Good Standing. The director shall not recognize any person or firm as a qualified independent certified public accountant that is not in good standing with the AICPA 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; or has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as indemnification) with respect to the audit of the insurer. (5-8-09)

02. Conformance with Ethical and Professional Standards. Except as otherwise provided in this rule, the director shall recognize an independent certified public accountant as qualified as long as he conforms to the standards of his profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Idaho Board of Public Accountancy, or similar code. (5-8-09)

03. Resolution of Disputes and Delinquency Proceedings. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Title 41, Chapter 33, the mediation or arbitration provisions shall operate at the option of the statutory successor. (5-8-09)

04. Capacity to Render Report for Consecutive Years. The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in the capacity for more than five (5) consecutive years. The 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 five (5) consecutive years. An insurer may make application to the director for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The director may consider the following factors in determining if the relief should be granted: (5-8-09)

a. Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm; (7-1-93)

b. Premium volume of the insurer; or (7-1-93)

c. Number of jurisdictions in which the insurer transacts business. (5-8-09)

05. Relief from Limitation on Consecutive Appointment of Lead Partner. The insurer shall file, with its annual statement filing, the approval for relief from Subsection 014.04 of this rule, with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. (5-8-09)

06. Grounds for Not Recognizing as Qualified. The director shall neither 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: (5-8-09)

a. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law; (5-8-09)

b. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or (5-8-09)

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. (5-8-09)

07. Hearings. The director of insurance may, as provided in Chapter 52, Title 67 and Chapter 2, Title 41, Idaho Code and IDAPA 04.11.01, hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his opinion on the financial statements in the annual Audited financial report made pursuant to this rule and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this rule. (5-8-09)

08. Prohibited Services. The director shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services: (5-8-09)

a. Bookkeeping or other services related to the accounting records or financial statements of the insurer; (5-8-09)

b. Financial information systems design and implementation; (5-8-09)

c. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports. (5-8-09)

d. Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met: (5-8-09)

i. Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions; (5-8-09)

ii. The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and (5-8-09)

iii. The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves; (5-8-09)

e. Internal audit outsourcing services; (5-8-09)

f. Management functions or human resources; (5-8-09)

g. Broker or dealer, investment adviser, or investment banking services; (5-8-09)

h. Legal services or expert services unrelated to the audit; or (5-8-09)

i. Any other services that the director determines, by rule, are impermissible. (5-8-09)

09. Principles of Independence. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three (3) basic principles, violations of which would impair the accountant's independence. The principles are that the accountant: (5-8-09)

a. Cannot function in the role of management; (5-8-09)

b. Cannot audit his own work; and (5-8-09)

c. Cannot serve in an advocacy role for the insurer. (5-8-09)

10. Exemption from Prohibited Services. Insurers having direct written and assumed premiums of less than one hundred million dollars (\$100,000,000) in any calendar year may request an exemption from Subsection 014.08 of this rule. The insurer shall file with the director a written statement discussing the reasons why the insurer should be exempt from these provisions. If the director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer, an exemption may be granted. (5-8-09)

11. Permitted Non-Audit Services. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection 014.08 of this rule, or that do not conflict with Subsection 014.09 of this rule, only if the activity is approved in advance by the Audit committee, in accordance with Subsection 014.12 of this rule. (5-8-09)

12. Preapproval Required by Audit Committee. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the Audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity; or (5-8-09)

a. The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided; (5-8-09)

b. The services were not recognized by the insurer at the time of the engagement to be non-audit services; and (5-8-09)

c. The services are promptly brought to the attention of the Audit committee and approved prior to the completion of the audit by the Audit committee or by one (1) or more members of the Audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit committee. (5-8-09)

13. Delegation by Audit Committee. The Audit committee may delegate to one (1) or more designated members of the Audit committee the authority to grant the preapprovals required by Subsection 014.12 of this rule. The decisions of any member to whom this authority is delegated shall be presented to the full Audit committee at each of its scheduled meetings. (5-8-09)

14. Prior Employment Prohibited. The director shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one (1) year period preceding the date that the most current statutory opinion is due. Subsection 014.14 of this rule, shall only apply to partners and senior managers involved in the audit. (5-8-09)

a. An insurer may make application to the director for relief from Subsection 014.14 of this rule, on the basis of unusual circumstances. (5-8-09)

b. The insurer shall file, with its annual statement filing, the approval for relief from Subsection 014.14 of this rule, with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. (5-8-09)

015. CONSOLIDATED OR COMBINED AUDITS.

An insurer may make written application to the director 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 that utilizes a pooling or one hundred percent (100%) 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: (5-8-09)

01. Worksheet. Amounts shown on the consolidated or combined Audited financial report shall be shown on the worksheet; (5-8-09)

02. Separate Amounts. Amounts for each insurer subject to this section shall be stated separately; (5-8-09)

03. Noninsurance Operations. Noninsurance operations may be shown on the worksheet on a combined or individual basis; (5-8-09)

04. Explanations of Consolidating and Eliminating Entries. Explanations of consolidating and eliminating entries shall be included; and (5-8-09)

05. Reconciliation. 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 statement of the insurers. (5-8-09)

016. SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT.

Financial statements furnished pursuant to Section 012 hereof shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. The independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by the standards of his profession, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 023, the independent certified public accountant should consider (as that term is defined in generally accepted auditing standards) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the 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. (5-8-09)

017. NOTIFICATION OF ADVERSE FINANCIAL CONDITION.

The insurer required to furnish the annual Audited financial report shall require the independent certified public accountant to report, in writing, within five (5) 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 director as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirements of Title 41, Idaho Code, as of that date. An insurer that has received a

report pursuant to this paragraph shall forward a copy of the report to the director within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the director. If the independent certified public accountant fails to receive such evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the director a copy of its report within the next five (5) business days. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with Section 017 if the statement is made in good faith in compliance with Section 017. If the accountant, subsequent to the date of the Audited financial report filed pursuant to this rule, becomes aware of facts which might have affected his report, the director notes the obligation of the accountant to take action as prescribed by the standards of his profession. (5-8-09)

018. COMMUNICATION OF INTERNAL CONTROL RELATED MATTERS NOTED IN AN AUDIT.

In addition to the annual audited financial report, each insurer shall furnish the director with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by the standards of his profession) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in Subsection 011.01, of this rule) in the insurer's Internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication. (5-8-09)

019. ACCOUNTANT'S LETTER OF QUALIFICATION.

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating: (5-8-09)

01. Independence. That the accountant is independent with respect to the insurer and conforms to the standards of his profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Idaho Board of Public Accountancy, or similar code; (5-8-09)

02. Background and Experience. 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 deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards; (5-8-09)

03. Compliance with Rule. That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this rule and that the director will be relying on this information in the monitoring and regulation of the financial position of insurers; (5-8-09)

04. Consent to Requirements of Section 020. That the accountant consents to the requirements of Section 020 of this rule and that the accountant consents and agrees to make available for review by the director, or the director's designee or appointed agent, the workpapers, as defined in Section 020; (5-8-09)

05. Properly Licensed. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and (5-8-09)

06. Compliance with Section 014. A representation that the accountant is in compliance with the requirements of Section 014 of this rule. (7-1-93)

020. DEFINITION, AVAILABILITY AND MAINTENANCE OF CERTIFIED PUBLIC ACCOUNTANTS WORKPAPERS.

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 accountant's audit 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 his audit of the

financial statements of an insurer and which support the accountant's opinion. Every insurer required to file an Audited financial report pursuant to this rule, shall require the accountant to make available for review by the insurance department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the office of the insurer, at the insurance department or at any other reasonable place designated by the director. The insurer shall require that the accountant retain the audit workpapers and communications until the insurance department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report. In the conduct of the aforementioned periodic review by the insurance department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department 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 department. (5-8-09)

021. REQUIREMENTS FOR AUDIT COMMITTEES.

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity. (5-8-09)

01. Responsibility. The Audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this chapter. Each accountant shall report directly to the Audit committee. (5-8-09)

02. Corporate Membership. Each member of the Audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection 021.05 and Section 010 of this rule. (5-8-09)

03. Independence. In order to be considered independent for purposes of Section 021, a member of the Audit committee may not, other than in his capacity as a member of the Audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit committee and be designated as independent for Audit committee purposes, unless they are an officer or employee of the insurer or one (1) of its affiliates. (5-8-09)

04. Continuation of Service. If a member of the Audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the director, may remain an Audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one (1) year from the occurrence of the event that caused the member to be no longer independent. (5-8-09)

05. Controlling Person. To exercise the election of the controlling person to designate the Audit committee for purposes of this rule, the ultimate controlling person shall provide written notice to the directors of insurance of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the director by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded. (5-8-09)

06. Accountant's Reports to Audit Committee. The Audit committee shall require the accountant that performs for an insurer any audit required by this rule to timely report to the Audit committee in accordance with the standards of his profession. If an insurer is a member of an insurance holding company system, the reports required by Subsection 021.06 of this rule, may be provided to the Audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit committee. The accountant's reports shall include: (5-8-09)

- a. All significant accounting policies and material permitted practices; (5-8-09)
- b. All material alternative treatments of financial information within statutory accounting principles

that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and (5-8-09)

c. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences. (5-8-09)

07. Required Proportion of Independent Audit Committee Members. The proportion of independent Audit committee members shall meet or exceed the following criteria: (5-8-09)

Prior Calendar Year Direct Written and Assumed Premiums		
\$0 - \$300,000,000	Over \$300,000,000 - \$500,000,000	Over \$500,000,000
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.
<p>Note A: The director has authority afforded by state law to require the entity's board to enact improvements to the independence of the Audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.</p> <p>Note B: All insurers with less than \$500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit committees with at least a supermajority of independent Audit committee members.</p> <p>Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.</p>		

(5-8-09)

08. Hardship Waiver. An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than five hundred million dollars (\$500,000,000) may make application to the director for a waiver from the Section 021 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 021 with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. (5-8-09)

022. CONDUCT OF INSURER IN CONNECTION WITH THE PREPARATION OF REQUIRED REPORTS AND DOCUMENTS.

01. False or Misleading Statements. No director or officer of an insurer shall, directly or indirectly make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this chapter. (5-8-09)

02. Omissions. No director or officer of an insurer shall, directly or indirectly omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this chapter. (5-8-09)

03. Coercion. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this chapter if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading. For purposes of Subsection 022.03 of this rule, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the

professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant: (5-8-09)

a. To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the director, generally accepted auditing standards, or other professional or regulatory standards); (5-8-09)

b. Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards; (5-8-09)

c. Not to withdraw an issued report; or (5-8-09)

d. Not to communicate matters to an insurer's Audit committee. (5-8-09)

023. MANAGEMENT'S REPORT OF INTERNAL CONTROL OVER FINANCIAL REPORTING.

01. Premium Threshold. Every insurer required to file an audited financial report pursuant to this chapter that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of five hundred million dollars (\$500,000,000) or more shall prepare a report of the insurer's or Group of insurers' Internal control over financial reporting, as these terms are defined in Section 010. The report shall be filed with the director along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 018. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding. (5-8-09)

02. RBC Level or Other Event. Notwithstanding the premium threshold in Subsection 023.01 of this rule, the director may require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one (1) or more of the standards of an insurer deemed to be in hazardous financial condition as defined in IDAPA 18.07.05, "Director's Authority for Companies Deemed to be in Hazardous Financial Condition." (5-8-09)

03. Section 404. An insurer or a Group of insurers may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section 023 requirement provided that those internal controls of the insurer or Group of insurers having a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in Subsections 012.02 through 012.07 of this rule) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or Group of insurers' audited statutory financial statements (those items included in Subsections 012.02 through 012.07 of this rule) excluded from the Section 404 Report. If there are internal controls of the insurer or Group of insurers that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or Group of insurers may either file: (5-8-09)

a. A Section 023 report; or (5-8-09)

b. The Section 404 Report and a Section 023 report for those internal controls that have a material impact on the preparation of the insurer's or Group of insurers' audited statutory financial statements not covered by the Section 404 Report, providing the insurer or Group of insurers is: (5-8-09)

i. Directly subject to Section 404; (5-8-09)

ii. Part of a holding company system whose parent is directly subject to Section 404; (5-8-09)

iii. Not directly subject to Section 404 but is a SOX Compliant Entity; or (5-8-09)

iv. A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity. (5-8-09)

04. Required Elements. Management's Report of Internal Control over Financial Reporting shall include: (5-8-09)

- a.** A statement that management is responsible for establishing and maintaining adequate Internal control over financial reporting; (5-8-09)
- b.** A statement that management has established Internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles; (5-8-09)
- c.** A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its Internal control over financial reporting; and (5-8-09)
- d.** A statement that briefly describes the scope of work that is included and whether any internal controls were excluded; (5-8-09)
- e.** Disclosure of any unremediated material weaknesses in the Internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the Internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one (1) or more unremediated material weaknesses in its Internal control over financial reporting; (5-8-09)
- f.** A statement regarding the inherent limitations of internal control systems; and (5-8-09)
- g.** Signatures of the chief executive officer and the chief financial officer (or equivalent position/title). (5-8-09)

05. Documentation by Management. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection 023.04 of this rule, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities. Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation. Management's Report on Internal Control over Financial Reporting, required by Subsection 023.01 of this rule, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Idaho Department of Insurance. (5-8-09)

024. EXEMPTIONS AND EFFECTIVE DATES.

01. Exemptions Not Otherwise Provided. Upon written application of any insurer, the director may grant an exemption from compliance with any and all provisions of this rule if the director finds, upon review of the application, that compliance with this rule 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 (10) days from a denial of an insurer's written request for an exemption from this chapter, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," pertaining to administrative hearing procedures. (5-8-09)

02. Domestic Insurer Effective Dates. Domestic insurers retaining a certified public accountant on the effective date of this rule who qualifies as independent shall comply with this rule for the year ending December 31, 2010, and each year thereafter unless the director permits otherwise. Domestic insurers not retaining a certified public accountant on the effective date of this rule who qualifies as independent may meet the following schedule for compliance unless the director permits otherwise. (5-8-09)

- a.** As of December 31, 2010, file with the director an audited financial report: (5-8-09)
- b.** For the year ending December 31, 2011 and each year thereafter, such insurers shall file with the director all reports and communication required by this chapter. (5-8-09)

03. Foreign Insurers. Foreign insurers shall comply with this rule for the year ending December 31, 2010, and each year thereafter, unless the director permits otherwise. (5-8-09)

04. Alternate Effective Date for Subsection 014.04 [Capacity to Render Report for Consecutive Years]. The requirements of Subsection 014.04 of this rule, shall be in effect for audits of the year beginning January 1, 2010 and thereafter. (5-8-09)

05. Alternate Effective Date for Section 021 [Requirements for Audit Committees]. The requirements of Section 021 are to be in effect January 1, 2010. An insurer or Group of insurers that is not required to have independent Audit committee members or only a majority of independent Audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one (1) of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one (1) of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements. (5-8-09)

06. Effective Date for Section 023 [Management's Report of Internal Control Over Financial Reporting]. The requirements of Section 023 are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or Group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements. (5-8-09)

025. CANADIAN AND BRITISH COMPANIES.

01. Annual Audited Financial Report. In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant. (5-8-09)

02. Letter Required in Section 013. For such insurers, the letter required in Section 013 shall state that the accountant is aware of the requirements relating to the annual Audited statement filed with the director pursuant to section 011 and shall affirm that the opinion expressed is in conformity with such requirements. (5-8-09)

026. INTERNAL AUDIT FUNCTION REQUIREMENTS.

01. Exemption. An insurer is exempt from the requirements of this section if: (4-11-19)

a. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than five hundred million dollars (\$500,000,000); and (4-11-19)

b. If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than one billion dollars (\$1,000,000,000). (4-11-19)

02. Function. The insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations. (4-11-19)

03. Independence. In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on

audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships. (4-11-19)

04. Reporting. The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings. (4-11-19)

05. Additional Requirements. If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level. (4-11-19)

027. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 05**

**18.07.05 – DIRECTOR'S AUTHORITY FOR COMPANIES DEEMED TO BE
IN HAZARDOUS FINANCIAL CONDITION**

000. LEGAL AUTHORITY.

This rule is adopted and promulgated by the Director pursuant to Idaho Code Sections 41-211, 41-327 and 41-3309, and Title 67, Chapter 52, Idaho Code. (10-1-93)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.05, "Director's Authority for Companies Deemed to be in Hazardous Financial Condition." (4-7-11)

02. Scope. The purpose of this rule is to set forth the standards which the Director may use for identifying insurers found to be 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. This rule shall not be interpreted to limit the powers granted the Director by any laws or parts of laws of this state, nor shall this rule be interpreted to supersede any laws or parts of laws of this state. (4-7-11)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of this rule, or to the documentation of compliance with this rule. These documents will be available for public inspection and copying in accordance with the Idaho Public Records Law, Title 74, Chapter 1, Idaho Code. (4-7-11)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General -- General Provisions." (4-7-11)

004. INCORPORATION BY REFERENCE.

This rule incorporates by reference the full text of the National Association of Insurance Commissioners Financial Condition Examiners Handbook and the National Association of Insurance Commissioners Annual Statement Instructions and Accounting Practices and Procedures Manual, pursuant to Sections 41-223 and 41-335, Idaho Code. Copies may be viewed at: (4-7-11)

01. Department. Idaho Department of Insurance, 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (4-7-11)

02. Industry Documents. NAIC Executive Headquarters, 2301 McGee Street, Suite 800, Kansas City, MO 64108-2662. NAIC website at <http://www.naic.org>. (4-7-11)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS, STREET ADDRESS, AND WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except weekends and legal holidays. (4-7-11)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (4-7-11)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (4-7-11)

04. Web Site Address. The department's website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Law, Title 74, Chapter 1, Idaho Code. (4-7-11)

007. -- 010. (RESERVED)

011. STANDARDS.

The following standards, either singly or in combination of two (2) or more, may be considered by the Director to determine whether the continued operation of any insurer transacting insurance business in this state might be deemed to be hazardous to its policyholders or creditors or to the general public. The Director may consider: (4-7-11)

01. Examination Reports. Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries. (4-7-11)

02. NAIC Insurance Regulatory Information System. The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports. (4-7-11)

03. Adequate Cash Provision. Whether the insurer has made 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 insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts. (4-7-11)

04. Reinsurance Program. 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. (10-1-93)

05. Operating Loss (50% of Surplus). Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required. (4-7-11)

06. Operating Loss (20% of Surplus). Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required. (4-7-11)

07. Insolvency of Affiliate, Subsidiary or Reinsurer. Whether a reinsurer, obligor, or any entity within the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations, and which in the opinion of the Director may affect the solvency of the insurer. (4-7-11)

08. Contingent Liabilities. Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the Director may affect the solvency of the insurer. (10-1-93)

09. Controlling Person. Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer. (10-1-93)

10. Receivables. The age and collectibility of receivables. (10-1-93)

11. Competence of Management. 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. (10-1-93)

12. Failure to Respond to Inquiries. Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry. (10-1-93)

13. Failure to Meet Filing Requirements. Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Director. (4-7-11)

14. False or Misleading Financial Statements. 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. (10-1-93)

15. Extensive Growth. 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. (10-1-93)

16. Cash Flow. Whether the company has experienced or will experience in the foreseeable future cash flow and/or liquidity problems. (10-1-93)

17. Reserves Compliance with Minimum Standards. Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice. (4-7-11)

18. Material Under-Reserving. Whether management persistently engages in material under-reserving that results in adverse development. (4-7-11)

19. Transactions Among Affiliates. Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets, capital gains or both do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature. (4-7-11)

20. Any Other Finding. Any other finding determined by the Director to be hazardous to the insurer's policyholders or creditors or to the general public. (4-7-11)

012. DIRECTOR'S AUTHORITY.

01. Determination of Financial Condition. For the purposes of making a determination of an insurer's financial condition under this rule, the Director may: (10-1-93)

a. Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding; (10-1-93)

b. Make appropriate adjustments, including disallowance, to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates, consistent with the NAIC Accounting Policies and Procedures Manual, state laws, and regulations; (4-7-11)

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; (10-1-93)

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 (12) month period. (10-1-93)

02. Issuance of Order. If the Director determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or creditors or to the general public, then the Director may, upon a determination, issue an order requiring the insurer to: (4-7-11)

a. Reduce the total amount of present and potential liability for policy benefits by reinsurance; (10-1-93)

b. Reduce, suspend or limit the volume of business being accepted or renewed; (10-1-93)

c. Reduce general insurance and commission expenses by specified methods; (10-1-93)

- d.** Increase the insurer’s capital and surplus; (10-1-93)
- e.** Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders; (10-1-93)
- f.** File reports in a form acceptable to the Director concerning the market value of an insurer’s assets; (10-1-93)
- g.** Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Director deems necessary; (10-1-93)
- h.** Document the adequacy of premium rates in relation to the risks insured; (10-1-93)
- i.** File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the Director; (10-1-93)
- j.** Correct corporate governance practice deficiencies and adopt and utilize governance practices acceptable to the Director; (4-7-11)
- k.** Provide a business plan to the Director in order to continue to transact business in the state; or (4-7-11)
- l.** Adjust rates for any non-life insurance product written by the insurer that the Director considers necessary to improve the financial condition of the insurer. (4-7-11)
- 03. Hearing.** Any insurer subject to an order under Subsection 012.02 may request a hearing to review that order pursuant to Title 41, Chapter 2, Idaho Code. (4-7-11)

013. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 06**

18.07.06 – RULES GOVERNING LIFE AND HEALTH REINSURANCE AGREEMENTS

000. LEGAL AUTHORITY.

This rule is adopted and promulgated by the Director pursuant to Idaho Code Sections 41-211, 41-335, 41-510, 41-511, 41-512 and 41-514, and Title 67, Chapter 52, Idaho Code. (10-1-93)

001. PURPOSE AND SCOPE.

01. Purpose. The purpose of this rule is to set forth standards for Reinsurance Agreements involving life insurance, annuities, or accident and sickness insurance (disability) in order that the financial statements of the life and health and property and casualty insurers writing health business and utilizing such agreements properly reflect the financial condition of the ceding and assuming insurer. (10-1-93)

a. The Idaho Insurance Department recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus. (10-1-93)

b. However, it is improper for a licensed 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. The terms of such agreements referred to herein and described in IDAPA 18.07.06, "Life and Health Reinsurance Agreements," Section 011 violate: (10-1-93)

i. Idaho Code Section 41-1306 relating to financial statements that do not properly reflect the financial condition of the ceding insurer; (10-1-93)

ii. Idaho Code Section 41-514 relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and (10-1-93)

iii. Idaho Code Sections 41-308(3), 41-327 and 41-3309 relating to creating a situation that may be hazardous to policyholders and the people of this State. (10-1-93)

02. Applicability. This rule applies to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers that are not subject to a substantially similar rule in their domiciliary state. This rule also similarly applies to licensed property and casualty insurers with respect to their accident and health business. This rule does not apply to assumption reinsurance or yearly renewable term reinsurance. (10-1-93)

002. -- 010. (RESERVED)

011. ACCOUNTING REQUIREMENTS.

01. Standards for Credit on Financial Statement. No insurer subject to this rule shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist: (10-1-93)

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). Those 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; (10-1-93)

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; (10-1-93)

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; (10-1-93)

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; (10-1-93)

e. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the insured 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; (10-1-93)

f. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identified for a representative sampling of 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. (10-1-93)

- i. Risk categories: (10-1-93)
 - (1) Morbidity. (10-1-93)
 - (2) Mortality. (10-1-93)
- ii. 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. (10-1-93)
- iii. 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. (10-1-93)
- iv. Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase. (10-1-93)
- v. 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.

Risk Category

Key: + - Significant
0 - Insignificant

	i.	ii.	iii.	iv.	v.	vi.
Health Insurance - other than LTC/LTD*	+	0	+	0	0	0
Health Insurance - 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	+	+	+	+
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 dump-in premiums allowed	0	+	+	+	+	+

*LTC = Long Term Care Insurance
 *LTD = Long Term Disability Insurance

(10-1-93)

g. Significant Risk.

(10-1-93)

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 IDAPA 18.07.06.011.01.g.ii.) 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 Director which legally segregates, by contract or contract provision, the underlying assets. (10-1-93)

ii. Notwithstanding the requirements of IDAPA 18.07.06.011.01.g.i., 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:

- Health 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 the net investment income as reported in Annual Statement

"CG" is capital gains less capital losses as reported in Annual Statement

"X" is the current year cash and invested assets plus investment income due and accrued less borrowed money as reported in Annual Statement

"Y" is the same as X but for the prior year

(10-1-93)

h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date. (10-1-93)

i. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured. (10-1-93)

j. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured. (10-1-93)

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. (10-1-93)

02. Director's Approval. Notwithstanding IDAPA 18.07.06.011.01, an insurer subject to this Rule may, with the prior approval of the Director, take such reserve credit or establish such asset as the Director may deem consistent with the Insurance Code and Rules, including actuarial interpretations or standards adopted by the Department. (10-1-93)

03. Filing of Reinsurance Agreements. (10-1-93)

a. Agreements entered into after the effective date of this Rule which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Director within thirty (30) days from 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 his Rule and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this Department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this Rule. (10-1-93)

b. Any increase in surplus net of federal income tax resulting from arrangements described in Subsection 011.03.a. 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 line 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 of the annual statement as earnings emerge from the business reinsured. (10-1-93)

i. For example: On the last day of calendar year N, company XYZ pays a twenty (\$20) million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a thirty-four percent (34%) tax rate, the net increase in surplus at inception is thirteen point two (\$13.2) million (twenty (\$20) million - six point eight (\$6.8) million) which is reported on the “Aggregate write-ins for gains and losses in surplus” line in the Capital and Surplus account. Six point eight (\$6.8) million (thirty-four (34%) of twenty (\$20) million) is reported as income on the “Commissions and expense allowances on reinsurance ceded” line of the Summary of Operations. (10-1-93)

ii. At the end of year N+1 the business has earned four (\$4) million. ABC has paid point five (\$.5) million in profit and risk charges in arrears for the year and has received a one million (\$1) million experience refund. Company ABC’s annual statement would report one point six five (\$1.65) million (sixty-six percent (66%) of (four (\$4) million - one (\$1) million - point five (\$.5) million) up to a maximum of thirteen point two (\$13.2) million) on the “Commissions and expense allowance on reinsurance ceded” line of the Summary of Operations, and -one point sixty five (\$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. (10-1-93)

012. WRITTEN AGREEMENTS.

01. Execution Date. 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 Department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the “as of date” of the financial statement. (10-1-93)

02. Letter of Intent. 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 (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded. (10-1-93)

03. Required Provisions. The reinsurance agreement shall contain provisions which provide that: (10-1-93)

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 (10-1-93)

b. Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties. (10-1-93)

013. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 07**

**18.07.07 – MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND
GROUP HEALTH INSURANCE CONTRACTS**

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to and in accordance with the provisions of Sections 41-211, 41-355 and 41-608, Idaho Code, and Title 67, Chapter 52, Idaho Code. (3-30-07)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.07, “Minimum Reserve Standards for Individual and Group Health Insurance Contracts.” (3-30-07)

02. Scope. These standards apply to all individual and group health (disability) insurance coverages including single premium credit disability insurance. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. these documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-30-07)

004. INCORPORATION BY REFERENCE.

The NAIC Accounting Practices and Procedures Manual as adopted by the Director pursuant to Section 41-335, Idaho Code, is hereby incorporated by reference. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-30-07)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

As used in this valuation standard, the following terms have the following meaning: (10-1-93)

01. NAIC Accounting Practices and Procedure Manual. The manual annually adopted and published by the National Association of Insurance Commissioners (NAIC), which contains statutory accounting guidance, as adopted by the director of the department of insurance in accordance with section 41-335, Idaho Code. (3-30-07)

011. MINIMUM RESERVE STANDARDS.

Unless otherwise prescribed or permitted, the Minimum Reserve Standards for Individual and Group Health Insurance Contracts set forth in the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual apply to all individual and group health (disability) insurance coverages including single premium credit disability insurance. All other credit insurance is not subject to this rule. (3-30-07)

012. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 08**

18.07.08 – CREDIT FOR REINSURANCE RULES

000. LEGAL AUTHORITY.

In accordance with Section 41-211, Idaho Code, the Director of the Idaho Department of Insurance shall promulgate rules implementing the provisions of Title 41, Idaho Code. (7-1-96)

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as Rules of the Department of Insurance, IDAPA 18.07.08, “Credit for Reinsurance Rules.” (7-1-99)

02. Scope. The purpose of this rule is to set forth rules and procedural requirements which the director deems necessary to carry out the Credit for Reinsurance provision, Section 41-515, Idaho Code. The actions and information required by this rule are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state. (3-28-18)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency has written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Office of the Rules Coordinator, 650 West State, Room 100, P.O. Box 83720, Boise, Idaho, 83720-0011. (7-1-96)

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by Chapter 2, Title 41, Idaho Code, the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code of IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-28-18)

004. INCORPORATION BY REFERENCE.

Consistent with National Association of Insurance Commissioners (NAIC) model regulation 786, the following documents applicable to letters of credit as referenced in Subsections 061.02, 081.05 and 081.06 of this rule, are incorporated by reference. (3-28-18)

01. Documents. Copies of the following documents may be obtained by contacting our office. (3-28-18)

a. The Purposes and Procedures Manual of the NAIC Investment Analysis Office, NAIC Securities Valuation Office and NAIC Structured Securities Group, December 31, 2016, edition, as referenced in Subsection 061.02. (3-28-18)

b. The Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 600 (UCP 600)), July 1, 2007, edition, as referenced in Subsection 081.05. (3-28-18)

c. The International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), 1998 edition, as referenced in Subsection 081.06. (3-28-18)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS – WEB ADDRESS.

The Department of Insurance is located at 700 W State St., Third Floor, Boise, ID 83702. The mailing address is PO Box 83720, Boise, ID 83720. The web address is www.doi.idaho.gov. Office hours are Monday-Friday, 8:00 am-5:00 pm. (3-28-18)

006. PUBLIC RECORDS ACT COMPLIANCE.

This rule is subject to and in compliance with the Public Records Act, Title 74, Chapter 1, Idaho Code. (3-28-18)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Beneficiary. When used in trust agreements qualified under this rule, 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). (3-28-18)

02. Grantor. 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 unlicensed, unaccredited assuming insurer. (3-28-18)

03. Mortgage-Related Security. Means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the securities valuation office of the NAIC and that either; (3-28-18)

a. Represents ownership of one (1) or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that: (3-28-18)

i. Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.A. Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; (3-28-18)

ii. Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Sections 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.A. Section 1703; or (3-28-18)

b. Is secured by one (1) or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of Subparagraphs 010.03.a.i. and 010.03.a.ii. (3-28-18)

04. Obligation. (3-28-18)

a. Losses Paid But Not Recovered. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer; (3-28-18)

b. Reserves for Reinsured Losses Reported and Outstanding; (3-28-18)

c. Reserves for Reinsured Losses Incurred But Not Reported; and (3-28-18)

d. Reserves for Allocated Reinsured Loss Expenses and Unearned Premiums. (3-28-18)

05. Promissory Note. When used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument. (3-28-18)

011. CREDIT FOR REINSURANCE – REINSURER LICENSED IN THIS STATE.

Pursuant to Section 41-515(2)(a), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this State as of statutory financial statement credit for reinsurance is claimed. (3-28-18)

012. -- 020. (RESERVED)

021. CREDIT FOR REINSURANCE -- ACCREDITED REINSURERS.

01. Accredited Reinsurers. Pursuant to Section 41-515(2)(b), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer must: (3-28-18)

a. File with the Idaho Department of Insurance a properly executed form AR-1 (attached as an exhibit to this rule) as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records; (3-28-18)

b. File with the director a certified copy of a certificate of authority or other acceptable evidence that it is licensed to transact insurance or reinsurance in at least one (1) state, or in the case of a U.S. branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one (1) state. (3-28-18)

c. File annually with the director a copy of its annual statement filed with the insurance department of its state of domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and (3-28-18)

d. Maintain a surplus as regards policyholders in an amount not less than twenty million dollars (\$20,000,000) or obtain the affirmative approval of the director upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. (3-28-18)

02. Denial of Accreditation. If the director determines that the assuming insurer has failed to meet or maintain any of these qualifications, he may upon written notice and hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this section with respect to reinsurance ceded after 9/1/97 if the assuming insurer's accreditation has been denied or revoked by the director, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the director after notice and hearing. (3-28-18)

022. -- 030. (RESERVED)

031. CREDIT FOR REINSURANCE -- REINSURER DOMICILED AND LICENSED IN ANOTHER STATE.

Pursuant to Section 41-515(2)(c), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which any date on which statutory financial statement credit for reinsurance is claimed: (3-28-18)

01. Applicable Domicile and License. Is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed in) a state which employs standards regarding credit for reinsurance substantially similar to those applicable under Section 41-515, Idaho Code, and this rule; (3-28-18)

02. Maintains Surplus. Maintains a surplus as regards policyholders in an amount not less than twenty million dollars (\$20,000,000); and (7-1-96)

03. Proper AR-1 Form Filed. Files a properly executed Form AR-1 with the director as evidence of its submission to this state's authority to examine its books and records. (7-1-96)

04. Provisions. The provisions of this section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this section, "substantially similar" standards means credit for reinsurance standards which the director determines equal or exceed the standards of Section 41-515, Idaho Code, and this rule. (3-28-18)

032. -- 040. (RESERVED)

041. CREDIT FOR REINSURANCE -- REINSURERS MAINTAINING TRUST FUNDS.

01. Trust Fund. Pursuant to Section 41-515(2)(d), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in Section 41-515(4), Idaho Code, for the payment of the valid claims of its United States domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the director substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the director to determine the sufficiency of the trust fund. (3-28-18)

02. Requirements. The following requirements apply to the following categories of assuming insurer: (7-1-96)

a. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States domiciled insurers, and in addition, the assuming insurer shall maintain a trustee surplus of not less than twenty million dollars (\$20,000,000), except as provided for in Paragraph 041.02.b. of this section. (3-28-18)

b. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the director or commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trustee surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flow, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trustee surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust. (3-28-18)

c. The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of: (3-28-18)

i. For insurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the respective underwriters' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any underwriter of the group; (3-28-18)

ii. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this rule, funds in trust in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and (3-28-18)

iii. In addition to these trusts, the group shall maintain a trustee surplus of which one hundred million dollars (\$100,000,000) shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account. (3-28-18)

d. The incorporated members of the group within the scope of Paragraph 041.02.c. of this section shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the director: (3-28-18)

i. An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or (3-28-18)

ii. If a certification is unavailable, a financial statement, prepared by independent public accountants, of each underwriter member of the group. (3-28-18)

e. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of ten billion dollars (\$10,000,000,000) (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and that has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall: (3-28-18)

i. Consist of funds in trust in an amount not less than the assuming insurers' several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group; (3-28-18)

ii. Maintain a joint trustee surplus of which one hundred million dollars (\$100,000,000) shall be held jointly for the benefit of U.S. domiciled ceding insurers of any member of the group; and (3-28-18)

iii. File a properly executed form AR-1 as evidence of the submission to the Idaho Department of Insurance's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. (3-28-18)

f. Within ninety (90) days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the director an annual certification of each underwriter member's solvency by the member's domiciliary regulators, and financial statements, prepared by independent public accountants, of each underwriter member of the group. (3-28-18)

03. Acceptable Form. (3-28-18)

a. Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the director or commissioner of the state where the trust is domiciled or the director or commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the director and commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that: (3-28-18)

i. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States. (7-1-96)

ii. Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States ceding insurers, their assigns and successors in interest. (3-28-18)

iii. The trust shall be subject to examination as determined by the director. (7-1-96)

iv. 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; and (7-1-96)

v. No later than February 28 of each year the trustees of the trust shall report to the director 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. (7-1-96)

b. 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 this subsection or if the grantor 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 director or commissioner with regulatory oversight

over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the director or commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund. (3-28-18)

c. The assets shall be distributed by and claims shall be filed with and valued by the director or commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies. (3-28-18)

d. If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the director or commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement. (3-28-18)

e. The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision. (3-28-18)

04. Liabilities. For purposes of this section, the term “liabilities” shall mean the assuming insurer’s gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include: (3-28-18)

a. For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance: (3-28-18)

i. Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer; (3-28-18)

ii. Reserves for losses reported and outstanding; (3-28-18)

iii. Reserves for losses incurred but not reported; (3-28-18)

iv. Reserves for allocated loss expenses; and (3-28-18)

v. Unearned premiums. (3-28-18)

b. For business ceded by domestic insurers authorized to write life, health and annuity insurance: (3-28-18)

i. Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums: (3-28-18)

ii. Aggregate reserves for accident and health policies; (3-28-18)

iii. Deposit funds and other liabilities without life or disability contingencies; and (3-28-18)

iv. Liabilities for policy and contract claims. (3-28-18)

05. Assets. Assets deposited in trusts established pursuant to Section 41-515(2), Idaho Code, and Section 041 of these rules shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in Section 41-515(4)(a), Idaho Code, clean, irrevocable, unconditional and “evergreen” letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in Section 41-515(4)(a), Idaho Code, and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under Paragraphs 041.05.a.v., 05.c., 05.e.ii. or 05.f. of this rule, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be

classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Section 41-515(2), Idaho Code, shall be invested only as follows: (3-28-18)

a. Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by: (3-28-18)

i. The United States or by any agency or instrumentality of the United States; (3-28-18)

ii. A state of the United States; (3-28-18)

iii. A territory, possession or other governmental unit of the United States; (3-28-18)

iv. An agency or instrumentality of a governmental unit referred to in Subparagraphs 041.05.a.ii. and 041.05.a.iii. if the obligations shall be by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or (3-28-18)

v. The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC. (3-28-18)

b. Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations: (3-28-18)

i. Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated; (3-28-18)

ii. Are insured by at least one (1) authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or (3-28-18)

iii. Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC. (3-28-18)

c. Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC. (3-28-18)

d. An investment made pursuant to the provisions of Paragraph 041.05.a., 041.05.b., or 041.05.c. of this subsection shall be subject to the following additional limitations: (3-28-18)

i. An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust; (3-28-18)

ii. An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust; (3-28-18)

iii. The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and (3-28-18)

- iv. Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under Subparagraphs 041.05.b.i. and 05.b.iii. of this subsection, but shall not exceed two percent (2%) of the assets of the trust. (3-28-18)
- e. Equity interests: (3-28-18)
- if: i. Investments in common shares or partnership interests of a solvent U.S. institution are permissible (3-28-18)
- and (1) Its obligations and preferred shares, if any, are eligible as investments under Paragraph 041.05.e.; (3-28-18)
- (2) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. Sections 78a to 78kk or otherwise registered pursuant to that act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under Paragraph 041.05.e. an amount exceeding one percent (1%) of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company; (3-28-18)
- ii. Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if: (3-28-18)
- (1) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and (3-28-18)
- (2) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development. (3-28-18)
- iii. An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to Paragraph 041.05.e., when added to the aggregate cost of other investments in equity interests then held pursuant to Paragraph 041.05.e., shall not exceed ten percent (10%) of the assets in the trust. (3-28-18)
- f. Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC. (3-28-18)
- g. Investment companies: (3-28-18)
- i. Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. Section 80a, are permissible investments if the investment company: (3-28-18)
- (1) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under Paragraph 041.05.a., 041.05.b., or 041.05.c. of this subsection or invests in securities that are determined by the director to be substantively similar to the types of securities set forth in Paragraph 041.05.a., 041.05.b., or 041.05.c. of this subsection; or (3-28-18)
- (2) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under Subparagraph 041.05.e.i. of this subsection; (3-28-18)
- ii. Investments made by a trust in investment companies under Paragraph 041.05.e. shall not exceed the following limitations: (3-28-18)
- (1) An investment in an investment company qualifying under Subparagraph 041.05.g.i.(1) of this subsection, shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in

qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust; and (3-28-18)

(2) Investments in an investment company qualifying under Subparagraph 041.05.g.i.(2) of this subsection, shall not exceed five percent (5%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to Subparagraph 041.05.e.i. of this subsection. (3-28-18)

h. Letters of Credit: (3-28-18)

i. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced. (3-28-18)

ii. The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence or willful misconduct, or both. (3-28-18)

06. Security by an Unauthorized Assuming Insurer. A specific security provided to a ceding insurer by an assuming insurer pursuant to Section 051 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section. (3-28-18)

042. CREDIT FOR REINSURANCE – CERTIFIED REINSURERS.

01. Certification and Security. Pursuant to Section 41-515(2)(e), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under Section 042 of this rule. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the director. The security shall be in a form consistent with the provisions of Section 41-515(2)(e) and (3), Idaho Code, and Sections 071, 081, or 091 of this rule the amount of security required in order for full credit to be allowed shall correspond with the following requirements:

Rating	Security Required
Secure - 1	0%
Secure - 2	10%
Secure - 3	20%
Secure - 4	50%
Secure - 5	75%
Vulnerable - 6	100%

(3-28-18)

b. Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions. (3-28-18)

c. The director shall require the certified reinsurer to post one hundred percent (100%), for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer. (3-28-18)

d. In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post

security for catastrophe recoverables for a period of one (1) year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the director. The one (1) year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral: (3-28-18)

- i. Line 1: Fire. (3-28-18)
- ii. Line 2: Allied Lines. (3-28-18)
- iii. Line 3: Farm owners multiple peril. (3-28-18)
- iv. Line 4: Homeowners multiple peril. (3-28-18)
- v. Line 5: Commercial multiple peril. (3-28-18)
- vi. Line 9: Inland Marine. (3-28-18)
- vii. Line 12: Earthquake. (3-28-18)
- viii. Line 21: Auto physical damage. (3-28-18)

e. Credit for reinsurance under Section 042 shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to Section 042 with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract. (3-28-18)

f. Nothing in this section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under Section 042. (3-28-18)

02. Certification procedure: (3-28-18)

a. The director shall post notice on the insurance department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The director may not take final action on the application until at least thirty (30) days after posting the notice required by Paragraph 042.02.a. (3-28-18)

b. The director shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with Subsection 042.01. The director shall publish a list of all certified reinsurers and their ratings (3-28-18)

c. In order to be eligible for certification, the assuming insurer shall meet the following requirements: (3-28-18)

i. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director pursuant to Subsection 042.03. (3-28-18)

ii. The assuming insurer must maintain capital and surplus, or its equivalent, of no less than two hundred fifty million dollars (\$250,000,000) calculated in accordance with Subparagraph 042.02.d.viii. of this section. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least two hundred fifty million dollars (\$250,000,000) and a central fund containing a balance of at least two hundred fifty million dollars (\$250,000,000). (3-28-18)

iii. The assuming insurer must maintain financial strength ratings from two (2) or more rating agencies deemed acceptable by the director. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one (1) factor used by the director in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following: (3-28-18)

- (1) Standard & Poor’s; (3-28-18)
- (2) Moody’s Investors Service; (3-28-18)
- (3) Fitch Ratings; (3-28-18)
- (4) A.M. Best Company; or (3-28-18)
- (5) Any other nationally recognized statistical rating organization. (3-28-18)

iv. The certified reinsurer must comply with any other requirements reasonably imposed by the director. (3-28-18)

d. Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following: (3-28-18)

i. The certified reinsurer’s financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The director shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two (2) financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

Rating	Best	S&P	Moody’s	Fitch
Secure - 1	A++	AAA	Aaa	AAA
Secure - 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure - 3	A	A+, A	A1, A2	A+, A
Secure - 4	A-	A-	A3	A-
Secure - 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable - 6	B, B-, C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

(3-28-18)

ii. The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations; (3-28-18)

iii. For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers); (3-28-18)

iv. For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (attached as exhibits to this rule); (3-28-18)

- v. The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership; (3-28-18)
- vi. Regulatory actions against the certified reinsurer; (3-28-18)
- vii. The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in following Subparagraph 042.02.d.viii.; (3-28-18)
- viii. For certified reinsurers not domiciled in the U.S., audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or with the permission of the state insurance director, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor). Upon the initial application for certification, the director will consider audited financial statements for the last three (3) years filed with its non U.S. jurisdiction supervisor; (3-28-18)
- ix. The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding; (3-28-18)
- x. A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The director shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and (3-28-18)
- xi. Any other information deemed relevant by the director. (3-28-18)
- e. Based on the analysis conducted under Subparagraph 042.02.d.v. of a certified reinsurer's reputation for prompt payment of claims, the director may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the director shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under Subparagraph 042.02.d.i. if the director finds that:
- i. More than fifteen percent (15%) of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more that are not in dispute and that exceed one hundred thousand dollars (\$100,000) for each cedent; or (3-28-18)
- ii. The aggregate amount of reinsurance recoverables on paid losses that are not in dispute that are overdue by ninety (90) days or more exceeds fifty million dollars (\$50,000,000). (3-28-18)
- f. The assuming insurer must submit a properly executed form CR-1 (attached as an exhibit to this rule) as evidence of its submission to the jurisdiction of this state, appointment of the director as an agent for service of process in this state, and agreement to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The director shall not certify any assuming insurer that is domiciled in a jurisdiction that the director has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards. (3-28-18)
- g. The certified reinsurer must agree to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers that is not otherwise public information subject to disclosure shall be exempted from disclosure under Title 74, Chapter 1, Idaho Code, and shall be withheld from public disclosure. The applicable information filing requirements are, as follows: (3-28-18)
- i. Notification within ten (10) days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefor; (3-28-18)

ii. Annually, Form CR-F or CR-S, as applicable per instructions adopted by the Idaho Department of Insurance. (3-28-18)

iii. Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in following Subparagraph 042.02.g.iv.; (3-28-18)

iv. Annually, audited financial statements (audited U.S. GAAP basis if available, audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the director, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor). Upon the initial certification, audited financial statements for the last three (3) years filed with the certified reinsurer's supervisor; (3-28-18)

v. At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers; (3-28-18)

vi. A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and (3-28-18)

vii. Any other information that the director may reasonably require. (3-28-18)

h. Change in Rating or Revocation of Certification. (3-28-18)

i. In the case of a downgrade by a rating agency or other disqualifying circumstance, the director shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of Subparagraph 042.02.d.i. (3-28-18)

ii. The director shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the director to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations. (3-28-18)

iii. If the rating of a certified reinsurer is upgraded by the director, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the director shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the director, the director shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer. (3-28-18)

iv. Upon revocation of the certification of a certified reinsurer by the director, the assuming insurer shall be required to post security in accordance with Section 061 of this rule in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with Section 041 of this rule, the director may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the director to be at high risk of uncollectibility. (3-28-18)

03. Qualified Jurisdictions. (3-28-18)

a. If, upon conducting an evaluation under Section 042 of this rule with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the director determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the director shall publish notice and evidence of such recognition in an appropriate manner. The director may establish a procedure to withdraw recognition of those jurisdictions that are no

longer qualified. (3-28-18)

b. In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The director shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the director as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the director, include, but are not limited to, the following: (3-28-18)

i. The framework under which the assuming insurer is regulated. (3-28-18)

ii. The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance. (3-28-18)

iii. The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction. (3-28-18)

iv. The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used. (3-28-18)

v. The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the director in particular. (3-28-18)

vi. The history of performance by assuming insurers in the domiciliary jurisdiction. (3-28-18)

vii. Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the director has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards. (3-28-18)

viii. Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization. (3-28-18)

ix. Any other matters deemed relevant by the director. (3-28-18)

c. A list of qualified jurisdictions shall be published through the NAIC committee process. The director shall consider this list in determining qualified jurisdictions. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification with respect to the criteria provided under Subparagraphs 042.03.b.i. through 042.03.b.ix. of this subsection. (3-28-18)

d. U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions. (3-28-18)

04. Recognition of Certification Issued by an NAIC Accredited Jurisdiction. (3-28-18)

a. If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the director has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the director requires. The assuming insurer shall be considered to be a certified reinsurer in this State. (3-28-18)

b. Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this State as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the director of any change in its status or rating within ten (10) days after receiving notice of the change. (3-28-18)

c. The director may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with Paragraph 042.02.h. of this subsection. (3-28-18)

d. The director may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the director suspends or revokes the certified reinsurer's certification in accordance with Paragraph 042.02.h., the certified reinsurer's certification shall remain in good standing in this State for a period of three (3) months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this State. (3-28-18)

05. Mandatory Funding Clause. In addition to the clauses required under Section 101 of this rule, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer. (3-28-18)

06. Notification Requirements. The director shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions. (3-28-18)

043. -- 050. (RESERVED)

051. CREDIT FOR REINSURANCE REQUIRED BY LAW.

Pursuant to Section 41-515(2)(f), Idaho Code, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 41-515(2)(a), (b), (c), (d), or (e), Idaho Code, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district or territory of the United States and any lawful national government. (3-28-18)

052. -- 060. (RESERVED)

061. ASSET OR REDUCTION FROM LIABILITY FOR REINSURANCE CEDED TO AN UNAUTHORIZED ASSUMING INSURER NOT MEETING THE REQUIREMENT OF SECTIONS 011, 021, 031, 041, 042, AND 051.

Pursuant to Section 41-515(3), Idaho Code, the director shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 41-515(2), Idaho Code, in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds 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 under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in Section 41-515(4)(b), Idaho Code. This security may be in the form of any of the following: (3-28-18)

01. Cash. (7-1-96)

02. Securities. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the NAIC Investment Analysis Office NAIC Securities Valuation Office and NAIC Structured Securities Group, and qualifying as admitted assets; (3-28-18)

03. Letters of Credit. Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in Section 41-515(4)(a), Idaho Code, effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer 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 (or confirming) 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; or (3-28-18)

- 04. Other.** Any Other Form of Security Acceptable to the Director. (3-28-18)
- 05. Other Provisions Applicable.** An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to Section 061 shall be allowed only when the requirements of Section 101 and the applicable portions of Sections 074, 075, 076, 081, and 091 of this rule are met. (3-28-18)
- 062. -- 070. (RESERVED)**
- 071. TRUST AGREEMENTS QUALIFIED UNDER IDAPA 18.07.08.061.** Sections 074, 075, and 076 apply to trust agreements qualified under Section 061. (3-28-18)
- 072. -- 073. (RESERVED)**
- 074. REQUIRED CONDITIONS.**
- 01. Who Shall Enter the Agreement.** 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 Section 41-515(4)(b), Idaho Code. (3-28-18)
- 02. Trust Account.** The trust agreement shall create a trust account into which assets shall be deposited. (7-1-99)
- 03. Who Shall Hold Assets in Trust Account.** All assets in the trust account shall be held by the trustee at the trustee's office in the United States. (3-28-18)
- 04. Provisions of Trust Agreement.** The Trust Agreement shall provide that: (7-1-99)
- a.** 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; (7-1-96)
- b.** No other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets; (3-28-18)
- c.** It is not subject to any conditions or qualifications outside of the trust agreement; and (7-1-96)
- d.** It shall not contain references to any other agreements or documents except as provided for under Subsections 074.11 and 074.12. (3-28-18)
- 05. Sole Benefit of Beneficiary.** The Trust Agreement shall be established for the sole benefit of the beneficiary. (7-1-99)
- 06. Required of Trustee.** The Trust Agreement shall require the trustee to: (7-1-99)
- a.** Receive assets and hold all assets in a safe place; (7-1-96)
- b.** 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; (7-1-96)
- c.** 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; (7-1-96)
- d.** Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account; (7-1-96)
- e.** 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 (7-1-96)

f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account. (7-1-96)

07. Written Notification of Termination. The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary. (3-28-99)

08. Subject to Laws of State in Which Trust is Established. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled. (3-28-18)

09. Prohibit Invasion of Trust Corpus. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the director), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced. (3-28-18)

10. Trustee Shall Be Liable. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence or willful misconduct, or both. (3-28-18)

11. Purposes for Applying Amounts Drawn Upon Trust Account. Notwithstanding other provisions of this rule, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the 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, only for the following purposes: (3-28-18)

a. 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; (7-1-96)

b. To make payment to the assuming insurer of any amounts held in the trust account that exceed one hundred two percent (102%) of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or (7-1-96)

c. 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 (10) 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 Section 41-515(4)(b), Idaho Code, apart from its general assets, in trust for such uses and purposes specified in Subsections 074.11.a. and 074.11.b. as may remain executory after such withdrawal and for any period after the termination date. (3-28-18)

12. Reinsurance Agreement Provisions. Notwithstanding other provisions of this rule, when a trust agreement is established to meet the requirements of Section 061 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the 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, only for the following purposes; (3-28-18)

- a. To pay or reimburse the ceding insurer for: (3-28-18)
- 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 on account of cancellations of the policies; and (3-28-18)
- 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 insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement; (3-28-18)
- b. To pay to the assuming insurer 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 (3-28-18)
- c. Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) 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 yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in Paragraphs 074.12.a. and 074.12.b. of this Subsection as may remain executory after withdrawal and for any period after the termination date. (3-28-18)

13. Trust Account Assets. Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by the Insurance Code or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement. (3-28-18)

075. PERMITTED CONDITIONS.

01. Resignation of Trustee. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) 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 (90) 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. (7-1-99)

02. Grantor's Rights. 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. (7-1-99)

03. Trustee's Authority to Invest. 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 current fair market value to the assets withdrawn and that are consistent with the restrictions in Paragraph 076.01.b. (3-28-18)

04. Transfer of Assets. 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. (7-1-99)

05. Termination of Trust Account. 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. (7-1-99)

076. ADDITIONAL CONDITIONS APPLICABLE TO REINSURANCE AGREEMENTS.

01. Reinsurance Agreement. A reinsurance agreement may contain provisions that: (3-28-18)

a. 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; (7-1-96)

b. 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; (7-1-96)

c. Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and (7-1-96)

d. 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: (7-1-96)

i. To pay or reimburse the ceding insurer for: (3-28-18)

(1) 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; (3-28-18)

(2) 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; and (3-28-18)

(3) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; (3-28-18)

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. (3-28-18)

02. Other Provisions of Reinsurance Agreement. The Reinsurance Agreement may also contain provisions that: (7-1-99)

a. Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided: (3-28-18)

i. The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the current fair market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or (3-28-18)

ii. After withdrawal and transfer, the current fair market value of the trust account is no less than one hundred and two percent (102%) of the required amount. (3-28-18)

b. Provide for the return of any amount withdrawn in excess of the actual amounts required for Paragraph 076.01.d. and for interest payments, at a rate not in excess of the prime rate of interest on such amounts.

- (3-28-18)
- c. Permit the award by any arbitration panel or court of competent jurisdiction of: (7-1-96)
 - i. Interest at a rate different from that provided in Paragraph 076.02.b.; (7-1-99)
 - ii. Court of arbitration costs; (7-1-96)
 - iii. Attorney's fees, and (7-1-96)
 - iv. Any other reasonable expenses. (7-1-96)

03. Financial Reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure. (7-1-96)

04. Existing Agreements. Notwithstanding the effective date of this rule, any trust agreement or underlying reinsurance agreement in existence prior to July 1, 1996 will continue to be acceptable until 7/1/96, at which time the agreements will have to be in full compliance with this rule for the trust agreement to be acceptable. (7-1-96)

05. Failure to Identify Beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in Section 010 shall not be construed to affect any actions or rights which the director may take or possess pursuant to the provisions of the laws of this state. (3-28-18)

077. -- 080. (RESERVED)

081. LETTERS OF CREDIT QUALIFIED UNDER SECTION 061.

01. Letters of Credit Under Section 061. The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution as defined in Section 41-515(4)(a), Idaho Code. 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 Subparagraph 081.08.a.i. 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). (3-28-18)

02. Heading of Letter. 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. (7-1-96)

03. Statement. 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. (7-1-96)

04. Term of Letter. The term of the letter of credit shall be for at least one (1) 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 (30) days' notice prior to the expiration date or nonrenewal. (7-1-96)

05. Disclosure Statement. 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 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution. (3-28-18)

06. Letter Subject to Uniform Customs and Practice. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), then the letter of credit shall specifically address and provide 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 36 of Publication 600 occur. (3-28-18)

07. Exception. If the letter of credit is issued by a United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in Subsection 081.01, then the following additional requirements shall be met: (3-28-18)

a. The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts, and (3-28-18)

b. The “evergreen clause” shall provide for thirty (30) days’ notice prior to the expiration date for nonrenewal. (7-1-96)

08. Reinsurance Agreement Provisions. (7-1-96)

a. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that: (3-28-18)

i. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover. (7-1-96)

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: (7-1-96)

(1) To pay or reimburse the ceding insurer for: (3-28-18)

(a) 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; (3-28-18)

(b) 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; and (3-28-18)

(c) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; (3-28-18)

(2) 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 reinsurance agreement remain unliquidated and undischarged ten (10) 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 U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in Subparagraph 081.08.a.ii. as may remain after withdrawal and for any period after the termination date. (3-28-18)

iii. All of the foregoing provisions of Paragraph 081.08.a. should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer. (3-28-18)

b. Nothing contained in Paragraph 081.08.a. shall preclude the ceding insurer and assuming insurer from providing for: (3-28-18)

i. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Paragraph 081.08.a.ii; or (3-28-18)

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. (3-28-18)

082. -- 090. (RESERVED)

091. 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. (7-1-96)

092. -- 100. (RESERVED)

101. REINSURANCE CONTRACT.

Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Sections 011, 021, 031, 041, 042, or 061 or otherwise in compliance with Section 41-515(2), Idaho Code, after the adoption of this rule unless the reinsurance agreement: (3-28-18)

01. Insolvency Clause. Includes a proper insolvency clause that stipulates, that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to Chapter 33, Title 41, Idaho Code; (3-28-18)

02. Jurisdiction. Includes a provision pursuant to Section 41-515(2), Idaho Code, whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel; and (3-28-18)

03. Reinsurance Intermediary Clause. Includes a proper reinsurance intermediary clause, if applicable, that stipulates that the credit risk for the intermediary is carried by the assuming insurer. (3-28-18)

102. -- 999. (RESERVED)

Credit for Reinsurance Model Regulation

FORM AR-1

CERTIFICATE OF ASSUMING INSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in

_____, hereby certify that
(name of state)

_____, ("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer's state of domicile)

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 _____
(ceding insurer's state of domicile)
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 _____ to examine
(ceding insurer's state of domicile)
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 _____
(ceding insurer's state of domicile)
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)

Model Regulation Service—January 2012

FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____,
(name of officer) (title of officer)
of _____, the assuming insurer
(name of assuming insurer)
under a reinsurance agreement with one or more insurers domiciled in _____,
in order to be considered for approval in this state, hereby certify that (name of state)
_____ (“Assuming Insurer”):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer’s state of domicile)
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 _____
(ceding insurer’s state of domicile)
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. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.
4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.
5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with [cite relevant provision of the state equivalent of the Credit for Reinsurance Model Regulation].
6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.
7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with [cite relevant provision of the state equivalent of the Credit for Reinsurance Model Regulation].
8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.
9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Credit for Reinsurance Model Regulation

Dated: _____
_____ (name of assuming insurer)

BY: _____
_____ (name of officer)

_____ (title of officer)

Model Regulation Service—January 2012

Form CR-F – PART 1
Assumed Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Company Code or ID Number	Name of Reinsured	Domiciliary Jurisdiction	Assumed Premium	Paid Losses and Loss Adjustment Expenses	Reinsurance On Known Case Losses and LAE	Cols. 6 + 7	Contingent Commissions Payable	Assumed Premiums Receivable	Unearned Premium	Funds Held By or Due From Reinsured Companies	Letters of Credit Posted	Amount of Assets Pledged or Collateral to Secure Letters of Credit	Amount of Assets Pledged or Collateral Held in Trust	
9999999 Totals														

786-37

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**IDAPA 18
TITLE 07
CHAPTER 09**

18.07.09 – PROPERTY AND CASUALTY ACTUARIAL OPINION RULE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapters 2, Idaho Code. (3-30-07)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.09, “Property and Casualty Actuarial Opinion Rule.” (3-30-07)

02. Scope. This rule shall apply to annual statements filed with the Director as of the end of the first full calendar year following the effective date of the rule, and shall apply to all property and casualty companies doing business in this State. This rule is intended to provide the Director of the Department of Insurance with additional means to monitor an insurer’s loss reserves in accordance with Section 41-610, Idaho Code. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-30-07)

004. INCORPORATION BY REFERENCE.

The National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions are hereby incorporated by reference. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS - STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-30-07)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043. (3-30-07)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 020. (RESERVED)

021. ACTUARIAL OPINION OF RESERVES AND SUPPORTING DOCUMENTATION.

01. Statement of Actuarial Opinion. Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an Appointed Actuary entitled “Statement of Actuarial Opinion.” This opinion shall be filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions. (3-30-07)

02. Actuarial Opinion Summary. (3-30-07)

a. Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an Actuarial Opinion Summary, written by the company's Appointed Actuary. This Actuarial Opinion Summary shall be filed in accordance with the appropriate National Association of Insurance Commissioners ("NAIC") Property and Casualty Annual Statement Instructions and shall be considered to be a document supporting the Actuarial Opinion required in Subsection 021.01 of this chapter. (3-30-07)

b. A company licensed but not domiciled in this state shall provide the Actuarial Opinion Summary upon request. (3-30-07)

03. Actuarial Report and Work Papers. (3-30-07)

a. An Actuarial Report and underlying work papers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each Actuarial Opinion. (3-30-07)

b. If the insurance company fails to provide a supporting Actuarial Report or work papers at the request of the Director of the Idaho Department of Insurance, or, after review, the Director determines the supporting Actuarial Report or work papers provided by the insurance company do not comply with the NAIC Property and Casualty Annual Statement Instructions or are otherwise unacceptable, the Director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion, and to prepare the supporting Actuarial Report or work papers. (3-30-07)

022. CONFIDENTIALITY.

01. The Statement of Actuarial Opinion. Shall be provided with the Annual Statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document. (3-30-07)

02. Actuarial Report. (3-30-07)

a. Documents, materials or other information in the possession or control of the Department of Insurance that are considered an Actuarial Report, work papers or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the Director in connection with the Actuarial Report, work papers or Actuarial Opinion Summary, will be considered to be exempt from public disclosure under Section 74-107(5), Idaho Code, of the Idaho Public Records Act. (3-30-07)

b. This provision shall not be construed to limit the Director's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the Director regarding disclosure of the documents, nor shall this section be construed to limit the Director's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the Director's official duties. (3-30-07)

03. Director's Duties. In order to assist in the performance of his duties, the Director may enter into agreements governing sharing and use of materials or information subject to Subsection 021.02 of this chapter with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities. (3-30-07)

04. Waiver. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the director in Section 022 or as a result of sharing as authorized in Subsection 021.03 of this chapter. (3-30-07)

023. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 10**

18.07.10 – ACTUARIAL OPINION AND MEMORANDUM RULE

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (7-1-97)

001. TITLE AND SCOPE.

01. Application of Rule. This rule applies to all life insurance companies and fraternal benefit societies doing business in this State and to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this State. This regulation shall be applied in a manner that allows the appointed actuary to utilize his or her professional judgment in performing the asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. However, the Director shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the Director's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items. (3-30-07)

02. Application to All Annual Statements. This rule shall be applicable to all annual statements filed with the office of the Director after the effective date. A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with Section 022 of this chapter, and a memorandum in support thereof in accordance with Section 023 of this chapter, shall be required each year. (3-30-07)

03. Purpose. The purpose of this rule is to prescribe: (3-30-07)

a. Guidelines and standards for statements of actuarial opinion which are to be submitted in accordance with Section 41-612(12), Idaho Code, and for memoranda in support thereof; (7-1-97)

b. Rules applicable to the appointment of an appointed actuary; and (3-30-07)

c. Guidelines as to the meaning of adequacy of reserves. (3-30-07)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying in accordance with the public records act. (3-30-07)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Chapter 2, Title 41, Idaho Code, and the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General." (3-30-07)

004. INCORPORATED BY REFERENCE.

There are no documents incorporated by reference. (3-30-07)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS -- STREET ADDRESS -- WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except weekends and legal holidays. (4-7-11)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-30-07)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702. (4-7-11)

04. Web Site Address. The department's website is <http://www.doi.idaho.gov>. (3-30-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-30-07)

007. -- 009. (RESERVED)

010. DEFINITIONS.

01. Actuarial Opinion. The opinion of an Appointed Actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy test in accordance with Section 022 of this chapter and with presently accepted Actuarial Standards. (3-30-07)

02. Actuarial Standards Board. The board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice. (7-1-97)

03. Annual Statement. Statement required by Section 41-335 of the Idaho Code to be filed by the company with the office of the Director annually. (7-1-97)

04. Appointed Actuary. Any individual who is appointed or retained in accordance with the requirements set forth in Subsection 021.03, of the chapter to provide the actuarial opinion and supporting memorandum as required by Section 41-612(12) of the Idaho Code. (3-30-07)

05. Asset Adequacy Analysis. An analysis that meets the standards and other requirements referred to in Subsection 021.04 of this chapter. It may take many forms, including, but not limited to, cash flow testing, sensitivity testing or applications of risk theory. (3-30-07)

06. Director. The Director of the Idaho Department of Insurance. (7-1-97)

07. Company. A life insurance company, fraternal benefit society or reinsurer subject to the provisions of this rule. (7-1-97)

08. Qualified Actuary. Any individual who meets the requirements set forth in Subsection 021.02 of this chapter. (3-30-07)

011. -- 020. (RESERVED)

021. GENERAL REQUIREMENTS.

01. Submission of Statement of Actuarial Opinion. (7-1-97)

a. There is to be included on or attached to Page one (1) of the annual statement for each year beginning with the year in which this rule becomes effective the statement of an appointed actuary, entitled "Statement of Actuarial Opinion," setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts, in accordance with Section 022 of this chapter. (3-30-07)

b. Upon written request by the company, the Director may grant an extension of the date for submission of the statement of actuarial opinion. (7-1-97)

02. Qualified Actuary. An individual who: (7-1-97)

a. Is a member in good standing of the American Academy of Actuaries; and (7-1-97)

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; and (7-1-97)

- c. Is familiar with the valuation requirements applicable to life and health insurance companies; and (7-1-97)
- d. Has not been found by the Director (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice and hearing to have; (3-30-07)
 - i. Violated any provision of, or any obligation imposed by any law in the course of his dealings as a qualified actuary; or (7-1-97)
 - ii. Been found guilty of fraudulent or dishonest practices; or (7-1-97)
 - iii. Demonstrated his incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary; or (7-1-97)
 - iv. Submitted to the Director during the past five (5) years, pursuant to this rule, an actuarial opinion or memorandum that the Director rejected because it did not meet the provisions including standards set by the Actuarial Standards Board; or (7-1-97)
 - v. Resigned or been removed as an actuary within the past five (5) 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 (7-1-97)
- e. Has not failed to notify the Director of any action taken by any Director of any other state similar to that under Subsection 021.02.d. of this chapter. (3-30-07)

03. Appointed Actuary. A qualified actuary who is appointed or retained to prepare the Statement of Actuarial Opinion required by this rule; either directly by or by the authority of the board of directors through an executive officer of the company. The company shall give the Director timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm) and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and shall state in such notice that the person meets the requirements set forth in Subsection 021.02 of this chapter. Once notice is furnished, no further notice is required with respect to this person, provided that the company shall give the Director timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements set forth in Subsection 021.02 of this chapter. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice shall so state and give the reasons for replacement. (3-30-07)

04. Standards for Asset Adequacy Analysis. The asset adequacy analysis required by this rule: (7-1-97)

- a. Shall conform to the Standards of Practice as promulgated by the Actuarial Standards Board and on any additional standards under this rule, which standards are to form the basis of the statement of actuarial opinion in accordance with Section 021 of this chapter; and (3-30-07)
- b. Shall be based on methods of analysis as are deemed appropriate for such purposes by the Actuarial Standards Board. (7-1-97)

05. Liabilities to Be Covered. (7-1-97)

- a. Under authority of Section 41-612(12), Idaho Code, the statement of actuarial opinion shall apply to all in force business on the statement date regardless of when or where issued, e.g., Aggregate Reserve for Life Contracts, Aggregate Reserve for Accident and Health Contracts, reserves for Deposit Type Contracts, and Claims for Life and Health Contracts as reported in Exhibits of the annual statement, and equivalent items in the separate account statement or statements of the annual statement. (3-30-07)
- b. If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company and calculated in accordance with methods set forth in

Section 41-612(12), Idaho Code, the company shall establish such additional reserve. (7-1-97)

c. Additional reserves established under Subsections 021.05.a. or 021.05.b. of this chapter and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation. (3-30-07)

022. STATEMENT OF ACTUARIAL OPINION BASED ON AN ASSET ADEQUACY ANALYSIS.

01. General Description. The statement of actuarial opinion submitted in accordance with this section shall consist of; (3-30-07)

a. A paragraph identifying the appointed actuary and his qualifications (see Subsection 022.02.a. of this chapter); (3-30-07)

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 022.02.b. of this chapter) and identifying the reserves and related actuarial items covered by the opinion which have not been so analyzed; (3-30-07)

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 022.02.c. of this chapter), supported by a statement of each such expert in the form prescribed by Subsection 022.05 of this chapter; and (3-30-07)

d. An opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (see Subsection 022.02.f. of this chapter). (3-30-07)

e. One (1) or more additional paragraphs will be needed in individual company cases as follows; (3-30-07)

i. If the appointed actuary considers it necessary to state a qualification of his opinion; (7-1-97)

ii. 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; (3-30-07)

iii. 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 (3-30-07)

iv. If the appointed actuary chooses to add a paragraph briefly describing the assumptions which form the basis for the actuarial opinion. (7-1-97)

02. Recommended Language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances should 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 should use language which clearly expresses his professional judgment. However, in any event the opinion shall retain all pertinent aspects of the language provided in this section. (7-1-97)

a. The opening paragraph should generally indicate the appointed actuary's relationship to the company and his qualifications to sign the opinion. For a company actuary, the opening paragraph of the actuarial opinion should read 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 said insurer to render this opinion as stated in the letter to the Director dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am

familiar with the valuation requirements applicable to life and health insurance companies.”

For a consulting actuary, the opening paragraph should contain a sentence such as:

“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 Director dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies.” (7-1-97)

b. The scope paragraph should include a statement such as 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.

TABLE 022.02.b.

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 Life Insurance					
Annuities					
Supplementary Contracts Involving Life Contingencies					
Accidental Death Benefit					
Disability - Active					
Disability - Disabled					
Miscellaneous					
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6 Active Life Reserve					
Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7 Premium and Other Deposit Funds (Column 6, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Annuities Certain (Column 3, Line 14)					

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)
Supplemental Contracts (Column 4, Line 14)					
Dividend Accumulations or Refunds (Column 5, Line 14)					
Total Exhibit 7					
Exhibit 8 Part 1 Life (Page 3, Line 4.1)					
Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1					
Separate Accounts (Page 3, Line 27)					
TOTAL RESERVES					
IMR (General Account, Page 3 Line 9.4)					
Separate Accounts, Page 3 Line 27					
AVR (Page 3 Line 24.1)	(c)				
Net Deferred and Uncollected Premiums					
Notes:					
(a) The additional actuarial reserves are the reserves established under Paragraph 021.05.b. or 021.05.c. of this chapter.					
(b) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in Subsection 021.04 of this chapter, by means of symbols which should be defined in footnotes to the table.					
(c) Allocated amount.					

(4-7-11)

c. If the appointed actuary has relied on other experts to develop certain portions of the analysis, the reliance paragraph should include a statement such as 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.”

(4-7-11)

i. Such a statement of reliance on other experts should be accompanied by a statement by each of the experts of the form prescribed by Subsection 022.05.

(3-30-07)

d. If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should also include the following:

“My examination included such review of the actuarial assumptions and actuarial methods and of the underlying

basic asset and liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement." (3-30-07)

e. If the appointed actuary has not examined the underlying records, but has relied upon data (e.g. listings and summaries of policies in force and/or asset records) prepared by the company, the reliance paragraph should include a sentence such as:

"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 such review of the actuarial assumptions and actuarial methods used and such tests of the calculations I considered necessary." (4-7-11)

i. Such a section must be accompanied by a statement by each person relied upon of the form prescribed by Subsection 022.05 of this chapter. (3-30-07)

f. The opinion paragraph should include the following:

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

- (a) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;
- (b) 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;
- (c) Meet the requirements of the Insurance Law and rule 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.
- (d) 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);
- (e) Include provision for all actuarial reserves and related statement items which ought to be established.

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

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

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

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

Note: Choose one (1) of the above two (2) paragraphs, whichever is applicable.

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

(4-7-11)

03. 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 022 of this chapter. (3-30-07)

04. Adverse Opinions. If the appointed actuary is unable to form an opinion, then he shall refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he shall issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for such opinion. This statement should follow the scope paragraph and precede the opinion paragraph. (7-1-97)

05. Reliance on Data Furnished by Other Persons. If the appointed 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 should so indicate 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 shall 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, as applicable, of the items. This certification shall include the signature, title, company, address and telephone number of the person rendering the certification, as well as the date on which it is signed. (3-30-07)

023. ALTERNATE OPTION.

01. Standard Valuation Law. The Standard Valuation Law gives the Director broad authority to accept the valuation of a foreign insurer when that valuation meets the requirements applicable to a company domiciled in this state in the aggregate. As an alternative to the requirements of part (c) in Paragraph 022.02.f. of this chapter, the Director may make one (1) or more of the following additional approaches available to the opening actuary: (3-30-07)

a. A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and the formal written standards and conditions of this state for filing an opinion based on the law of the state of domicile." If the Director chooses to allow this alternative, a formal written list of standards and conditions shall be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year shall apply to statements for that calendar year, and they shall remain in effect until they are revised or revoked. If no list is available, this alternative is not available. (3-30-07)

b. A statement that the reserves "meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have verified that the company's request to file an opinion based on the law of the state of domicile has been approved and that any conditions required by the Director for approval of that request have been met." If the Director chooses to allow this alternative, a formal written statement of such allowance shall be

issued no later than March 31 of the year it is first effective. It shall remain valid until rescinded or modified by the Director. The rescission or modifications shall be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company shall file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request shall be deemed approved on October 1 of that year if the Director has not denied the request by that date. (3-30-07)

c. A statement that the reserves “meet the requirements of the insurance laws and regulations of the State of [state of domicile] and I have submitted the required comparison as specified by this state.” (3-30-07)

i. If the Director chooses to allow this alternative, a formal written list of products (to be added to the table in Item (ii) below) for which the required comparison shall be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year shall apply to statements for that calendar year, and it shall remain in effect until it is revised or revoked. If no list is available, this alternative is not available. (3-30-07)

ii. If a company desires to use this alternative, the appointed actuary shall provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under NAIC codification standards. Gross nationwide reserves are the total reserves calculated for the total company in force business directly sold and assumed, indifferent to the state in which the risk resides, without reduction for reinsurance ceded. The information provided shall be at least:

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(3-30-07)

iii. The information listed shall include all products identified by either the state of filing or any other states subscribing to this alternative. (3-30-07)

iv. If there is no codification standard for the type of product or risk in force or if the codification standard does not directly address the type of product or risk in force, the appointed actuary shall provide detailed disclosure of the specific method and assumptions used in determining the reserves held. (3-30-07)

v. The comparison provided by the company is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum. (3-30-07)

d. Notwithstanding the above, the Director may reject an opinion based on the laws and regulations of the state of domicile and require an opinion based on the laws of this state. If a company is unable to provide the opinion within sixty (60) days of the request or such other period of time determined by the Director after consultation with the company, the Director may contract with an independent actuary at the company’s expense to prepare and file the opinion. (3-30-07)

024. DESCRIPTION OF ACTUARIAL MEMORANDUM INCLUDING AN ASSET ADEQUACY ANALYSIS AND REGULATORY ASSET ADEQUACY ISSUES SUMMARY.

01. General. (7-1-97)

a. In accordance with Section 41-612(12), Idaho Code, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his opinion regarding the reserves. The memorandum shall be made available for examination by the Director upon his request but shall be returned to the company after such examination and shall not be considered a record of the insurance department or subject to automatic filing with the Director. (4-7-11)

b. In preparing the memorandum, the appointed actuary may rely on, and include as a part of his own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Subsection 021.02 of this chapter, with respect to the areas covered in such memoranda, and so state in their memoranda. (3-30-07)

c. If the Director requests a memorandum and no such memorandum exists or if the Director 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 Rule, the Director may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Director. (4-7-11)

d. The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Director; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as examination workpapers and shall be kept confidential to the same extent as is prescribed by Section 41-227, Idaho Code. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this rule for any one of the current year or the preceding three (3) years. (7-1-97)

e. In accordance with Section 41-612(12), Idaho Code, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection 024.03 of this chapter. The regulatory asset adequacy issues summary will 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. The regulatory asset adequacy issues summary will be maintained as confidential and not subject to public disclosure by the director in accordance with Section 41-612(12), Idaho Code, and Section 74-107(5) of the Idaho Public Records Act. (3-30-07)

f. In accordance with Section 41-612(12)(d)(iv), the director will accept the regulatory asset adequacy issues summary of a foreign or alien company filed by that company with the insurance supervisory official of another state if the director determines that the summary reasonably meets the requirements applicable to a company domiciled in Idaho. Therefore, foreign or alien insurers required to file the regulatory asset adequacy issues summary in their home state are exempt from filing in this state, except upon request of the director, provided the other state has substantially similar reporting requirements and the summary is filed with the director of the other state within the time specified. (5-8-09)

02. Details of the Memorandum Section Documenting Asset Adequacy Analysis (Section 022). When an actuarial opinion under Section 022 of this chapter is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Subsection 021.04 of this chapter and any additional standards under this rule. It shall specify; (3-30-07)

- a.** For reserves; (3-30-07)
 - i.** Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant; (7-1-97)
 - ii.** Source of liability in force; (7-1-97)
 - iii.** Reserve method and basis; (7-1-97)
 - iv.** Investment reserves; (7-1-97)
 - v.** Reinsurance arrangements; and (3-30-07)
 - 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. (3-30-07)

- b.** Documentation of assumptions to test reserves for the following: (3-30-07)

 - i. Lapse rates (both base and excess); (3-30-07)
 - ii. Interest crediting rate strategy; (3-30-07)
 - iii. Mortality; (3-30-07)
 - iv. Policyholder dividend strategy; (3-30-07)
 - v. Competitor or market interest rate; (3-30-07)
 - vi. Annuitization rates; (3-30-07)
 - vii. Commissions and expenses; and (3-30-07)
 - viii. Morbidity. (3-30-07)
 - ix. The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. (3-30-07)
- c.** For assets: (7-1-97)

 - i. Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets; (7-1-97)
 - ii. Investment and disinvestment assumptions; (7-1-97)
 - iii. Source of asset data; (7-1-97)
 - iv. Asset valuation bases. (7-1-97)
- d.** Documentation of assumptions made for the following assets: (3-30-07)

 - i. Default costs; (3-30-07)
 - ii. Bond call function; (3-30-07)
 - iii. Mortgage prepayment function; (3-30-07)
 - iv. Determining market value for assets sold due to disinvestment strategy; and (3-30-07)
 - v. Determining yield on assets acquired through the investment strategy. (3-30-07)
 - vi. The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. (3-30-07)
- e.** For the analysis basis: (4-7-11)

 - i. Methodology; (7-1-97)
 - ii. Rationale for inclusion/exclusion of different blocks of business and how pertinent risks were analyzed; (7-1-97)
 - iii. Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of “materiality” that was used in determining how rigorously to analyze different blocks of business); (4-7-11)

iv. Criteria for determining asset adequacy (include in the criteria 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); (4-7-11)

v. Whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis. (4-7-11)

f. Summary of material changes in methods, procedures, or assumptions from prior year’s asset adequacy analysis; (3-30-07)

g. Summary of Results; (7-1-97)

h. Conclusion(s). (7-1-97)

03. Details of the Regulatory Asset Adequacy Issues Summary. (3-30-07)

a. The regulatory asset adequacy issues summary shall include: (3-30-07)

i. Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by 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; (3-30-07)

ii. The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis; (3-30-07)

iii. 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; (3-30-07)

iv. Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods; (4-7-11)

v. 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; and (3-30-07)

vi. Whether the actuary has been 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. (3-30-07)

b. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion. (3-30-07)

04. Conformity to Standards of Practice. The memorandum shall include a statement:

“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.” (7-1-97)

05. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve. 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. The amount of the assets used for the AVR must be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets must be disclosed in the memorandum. (7-1-97)

06. Documentation. The appointed actuary shall retain on file, for at least seven (7) 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. (7-1-97)

025. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 11**

18.07.11 – MUTUAL INSURANCE HOLDING COMPANY RULES

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (7-1-99)

001. TITLE AND SCOPE.

01. Title. This rule is titled Rules of the Idaho Department of Insurance, IDAPA 18.07.11, “Mutual Insurance Holding Company Rule.” (7-1-99)

02. Scope. The purpose and intent of this rule is to implement the provisions of Title 41, Chapter 38, Section 41-3824, Idaho Code, by providing: (7-1-99)

a. The formation of a mutual insurance holding company through an application process subject to regulation by the Department of Insurance. A domestic mutual insurance company may reorganize by forming a mutual insurance holding company based upon a mutual plan. The reorganized insurance company shall continue, without interruption, its corporate existence as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is a subsidiary to the mutual insurance holding company. (7-1-99)

b. The reorganization of a domestic mutual insurance company by merging its policyholders’ membership interests into a mutual insurance holding company and continuing, without interruption, the corporate existence of the reorganized insurance company as a stock insurance company subsidiary to the mutual insurance holding company or as a stock insurance company subsidiary to an intermediate holding company which is a subsidiary to the mutual insurance holding company through an application process subject to regulation by the Department of Insurance. (7-1-99)

c. An application process for the approval of an initial sale of the shares of the capital stock of a reorganized domestic insurance company or an intermediate holding company, subject to the approval of the Department of Insurance. (7-1-99)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. these documents will be available for public inspection and copying at cost in the main office of this agency. (7-1-99)

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (7-1-99)

004. DEFINITIONS.

For the purposes of this rule the following terms will be used as defined below: (7-1-99)

01. Affiliated Person. Affiliated person of another person means: (7-1-99)

a. Any person directly or indirectly owning, controlling, or holding with power to vote, five percent (5%) or more of the outstanding voting securities of such other person; or (7-1-99)

b. Any person, five percent (5%) or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person; or (7-1-99)

c. Any person directly or indirectly controlling, controlled by, or under common control with, such other person; or (7-1-99)

- d.** Any officer, director, partner, copartner, or employee of such other person. (7-1-99)
- 02.** **Director.** The Director of the Idaho Department of Insurance. (7-1-99)
- 03.** **Department.** The Idaho Department of Insurance. (7-1-99)
- 04.** **Domestic Mutual Insurance Company.** An insurance company organized on a mutual plan and incorporated under the laws of the state of Idaho. (7-1-99)
- 05.** **Interested Person.** Interested person of another person means: (7-1-99)
- a.** Any affiliated person of such person or company; or (7-1-99)
- b.** Any member of the immediate family of any natural person who is an affiliated person of such company; or (7-1-99)
- c.** Any person or partner or employee of any person who at any time since the beginning of the last two completed fiscal years of such company has acted as acted as legal counsel for such company; or (7-1-99)
- d.** Any natural person whom the Director by order shall have determined to be an interested person by reason of having had, at any time since the beginning of the last two completed fiscal years of such company, a material business or professional relationship with such company or with the principal executive officer of such company. (7-1-99)
- 06.** **Intermediate Holding Company.** A holding company which is a subsidiary of a mutual insurance holding company or part of a holding company system controlled by a mutual insurance holding company pursuant to the provisions of Title 41, Chapter 38, Idaho Code. (7-1-99)
- 07.** **Limited Application.** An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which will hold, at all times, one hundred percent (100%) of the stock of its insurance subsidiaries. (7-1-99)
- 08.** **Member of the Immediate Family.** Any parent, spouse of a parent, child, spouse of a child, spouse, brother or sister, and includes step and adoptive relationships. (7-1-99)
- 09.** **Mutual Insurance Holding Company.** A holding company organized of a mutual plan and incorporated under the laws of the state of Idaho, resulting from the reorganization of a domestic mutual insurance company pursuant to the provisions of Title 41, Chapter 38, Section 41-3824, Idaho Code, with one (1) or more stock insurance holding company subsidiaries or stock insurance company subsidiaries. A mutual insurance holding company shall be a person as defined in this chapter, and shall be subject to the provisions of Title 41, Idaho Code. (7-1-99)
- 10.** **Plan of Reorganization.** A plan to reorganize a domestic mutual insurance company by forming a mutual insurance holding company. (7-1-99)
- 11.** **Standard Application.** An application by a domestic mutual insurance company for reorganization to a mutual insurance holding company which may sell interests in its subsidiaries to third parties. (7-1-99)
- 12.** **Stock.** Any security evidencing an equity interest in the issuing entity. (7-1-99)
- 13.** **Stock Offering.** Any proposed sale, exchange, transfer or other change of ownership of stock or of securities convertible into or exchangeable or exercisable for stock. For the purposes of this chapter, "stock offering" shall not mean: (7-1-99)
- a.** An offering of preferred stock which is not convertible or exchangeable into common stock and which has no ordinary voting rights; or (7-1-99)

- b. A transfer of stock between any of the following: (7-1-99)
 - i. A mutual insurance holding company; or (7-1-99)
 - ii. An insurance company subsidiary of a mutual insurance holding company; or (7-1-99)
 - iii. An intermediate holding company subsidiary of a mutual insurance holding company; or (7-1-99)
 - iv. An insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company. (7-1-99)

005. APPLICATION - CONTENT - PROCESS.

01. Designation of Application as Limited or Standard. An application shall be designated as either a limited application or a standard application. The filing of a limited application shall not preclude the subsequent filing of an application for approval of an initial sale of stock as provided in this chapter. (7-1-99)

02. Information to be Contained in Application. The application shall be filed in duplicate with the Director and shall include the following information: (7-1-99)

- a. Designation as a limited or standard application; and (7-1-99)
- b. A plan of reorganization as set forth in this chapter; and (7-1-99)
- c. A plan to obtain the approval of the policyholders in accordance with the applicant's articles of incorporation and bylaws. Policyholders shall be given not less than twenty (20) days notice of any vote on approval of reorganization; and (7-1-99)
- d. A copy of the mutual insurance holding company's proposed articles of incorporation and bylaws specifying all membership rights; and (7-1-99)
- e. The names, addresses and occupational information of all corporate officers and member of the initial mutual insurance holding company board of directors; and (7-1-99)
- f. Information sufficient to demonstrate that the financial condition of the applicant will not be diminished upon reorganization; and (7-1-99)
- g. A copy of the proposed articles of incorporation and bylaws for any insurance company subsidiary or intermediate holding company subsidiary; and (7-1-99)
- h. A "Form A" filing as described in IDAPA 18.07.01, "Rules Pertaining to Idaho Acquisitions of Control and Insurance Holding Company Systems"; and (7-1-99)
- i. An index demonstrating where in the application information supplied in compliance with each of these rules is found; and (7-1-99)
- j. Any other information requested by the Director at any time during the course of proceedings. (7-1-99)

006. NOTICE OF HEARING.

01. Scheduling of Hearing. Upon receipt and review by the Director of all information provided pursuant to Section 005 above, a hearing shall be held as provided in Title 41, Chapter 38, Section 41-3824, Idaho Code. (7-1-99)

02. Evidence to be Presented at Hearing. At hearing, the application shall present evidence

establishing: (7-1-99)

a. The application is in compliance with all pertinent sections of the Idaho Insurance Code and Administrative Rules; and (7-1-99)

b. The requirements for a plan of reorganization have been fulfilled. (7-1-99)

03. Notice of Hearing. Notice of the hearing shall be given at least twenty (20) days prior to the hearing by the Department by regular mail to all interested parties known to the Department. (7-1-99)

007. PLAN OF REORGANIZATION.

01. Limited Application. A limited application plan of reorganization shall include provisions as follows: (7-1-99)

a. Establishing a mutual insurance holding company with at least one stock insurance company subsidiary or one intermediary stock holding company with a stock insurance company subsidiary, the share of which shall be held exclusively by the mutual insurance holding company; and (7-1-99)

b. Protection of the interests of existing policyholders; and (7-1-99)

c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganized domestic mutual insurance company; and (7-1-99)

d. Describing a plan providing for membership interests of future policyholders; and (7-1-99)

e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders; and (7-1-99)

f. Demonstrating that, in the event of proceedings under Title 41, Chapter 33, Idaho Code, involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company; and (7-1-99)

g. Describing a plan how any accumulation or prospective accumulation of earnings by the mutual insurance holding company which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members; and (7-1-99)

h. Describing the nature and content of the annual report and financial statement to be sent to each member; and (7-1-99)

i. For other matters, as the applicant deems appropriate. (7-1-99)

02. Standard Application. A standard application plan of reorganization shall include provisions as follows: (7-1-99)

a. Establishing a mutual insurance holding company with at least one (1) stock insurance company subsidiary or one (1) wholly-owned intermediate stock holding company with a stock insurance company subsidiary, the shares of which shall be held exclusively by the wholly owned intermediate holding company; and (7-1-99)

b. Protection of the interests of existing policyholders; and (7-1-99)

c. Ensuring immediate membership in the mutual insurance holding company of all existing policyholders of the reorganizing domestic mutual insurance company; and (7-1-99)

d. Providing for membership interests of future policyholders; and (7-1-99)

e. Describing the number of members of the board of directors of the mutual insurance holding company required to be policyholders; and (7-1-99)

f. Demonstrating that, in the event of proceedings under Title 41, Chapter 33, Idaho Code, involving a stock insurance company subsidiary of the mutual insurance holding company which resulted from the reorganization of a domestic mutual insurance company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurance company; and (7-1-99)

g. Describing how any accumulation or prospective accumulation of earnings by the mutual insurance holding company, which is or would be in excess of that determined by the board of directors of the mutual insurance holding company to be necessary, shall inure to the exclusive benefit of the policyholders of its insurance company subsidiaries who are members; and (7-1-99)

h. Describing the nature and content of the annual report and financial statement to be sent to each member; and (7-1-99)

i. Describing the applicant's plan for a stock offering in accordance with the provisions of this chapter; and (7-1-99)

j. Describing other relevant matters the applicant deems appropriate. (7-1-99)

03. Plan of Reorganization. With regard to either a limited or standard application, the plan of reorganization submitted to the Director shall demonstrate: (7-1-99)

a. Policyholder interests are properly preserved and protected; and (7-1-99)

b. The plan is fair and equitable to policyholders; and (7-1-99)

c. The financial condition of the applicant will not be diminished. (7-1-99)

008. DUTIES OF THE DIRECTOR.

01. Director Shall Retain Jurisdiction. The Director shall at all times retain jurisdiction over the mutual insurance holding company and its intermediate holding company subsidiaries with stock insurance company subsidiaries. (7-1-99)

02. Approval or Denial of Application. Following the hearing provided for in this chapter, the Director shall, by order, approve, conditionally approve, or deny the application. (7-1-99)

a. Conditions of approval. The Director may require, as a condition of approval of the proposed reorganization, such modifications of the proposed plan of reorganization as the Director finds necessary. The applicant shall accept such required modifications by filing appropriate amendments to the proposed plan of reorganization with the Director within thirty (30) days of the date of the order of the Director requiring such modifications. If the applicant does not accept such required modifications by failing to file the required amendments to the proposed plan of reorganization within thirty (30) days, the proposed reorganization shall be deemed denied. (7-1-99)

b. Expiration of conditional approval. An approval or conditional approval of a plan of reorganization shall expire if the reorganization is not completed within one hundred eighty (180) days unless such time period is extended by the Director upon a showing of good cause. (7-1-99)

c. Revocation of approval. The Director may revoke approval or conditional approval of an applicant's plan of reorganization in the event the Director finds the applicant has failed to comply with the plan of reorganization. The Director may compel completion of a plan of reorganization unless the plan is abandoned in its entirety, in accordance with the applicant's provisions for governance. The Director shall retain jurisdiction over the applicant until a plan of reorganization has been completed. (7-1-99)

d. Notice of completion. Upon completion of all elements of a plan of reorganization, the applicant shall provide a notice of completion to the Director. (7-1-99)

009. REGULATION - COMPLIANCE.

01. Compliance With Insurance Holding Company Law Required. Mutual insurance holding companies shall comply with the provisions of Title 41, Chapter 38, Idaho Code, except as expressly provided herein. (7-1-99)

02. Waiver of Compliance Not Allowed. No regulatory standards are waived during the pendency of an application of an application for a plan of reorganization. (7-1-99)

03. Approval of Merger or Acquisition Required. Mergers and acquisitions by a mutual insurance holding company must be approved by the Director pursuant to Title 41, Chapter 38, Idaho Code. At such time as a mutual insurance holding company acquires or plans to acquire more than fifty percent (50%) of a stock insurance company, the mutual insurance holding company shall submit to the Director a plan describing any membership interests of policyholders. (7-1-99)

04. Mutual Holding Company Annual Financial Statement Filing. Each mutual insurance holding company shall supply to the Department, by June 1 of each year, an annual statement consisting of the following: (5-3-03)

- a. An income statement; and (7-1-99)
- b. A balance sheet; and (7-1-99)
- c. A cash flow statement; and (7-1-99)
- d. Complete information on the status of any closed block formed as a part of a plan of reorganization; and (7-1-99)
- e. An investment plan covering all assets; and (7-1-99)
- f. A statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company. (7-1-99)

05. Insurance Company Subsidiary Investment Requirements for Mutual Holding Company. At least fifty percent (50%) of the generally accepted accounting practices (GAAP) basis net worth of a mutual insurance holding company shall be invested in insurance company subsidiaries. (7-1-99)

06. Approval Required for Distribution to Policyholders. No policyholder who is a member of a mutual insurance holding company shall receive on account of such membership interest any payment of a policy credit, dividend or other distribution unless such payment has been approved by the Director. The Director, after a public hearing as provided in Title 41, Chapter 38, Idaho Code, if satisfied the proposed payment is fair and equitable to policyholders who are members, may approve the proposed payment and may require as a condition of such approval modification of the proposed payment as the Director finds necessary for the protection of such policyholders. (7-1-99)

010. REORGANIZATION OF DOMESTIC MUTUAL INSURER WITH MUTUAL INSURANCE HOLDING COMPANY.

A domestic mutual insurance company may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the Director a joint application with the mutual insurance holding company complying with the provisions of this chapter. (7-1-99)

011. REORGANIZATION OF FOREIGN MUTUAL INSURER WITH MUTUAL INSURANCE HOLDING COMPANY.

A foreign mutual insurance company, or a foreign health service corporation, which if a domestic corporation would be organized under Title 41, Chapter 28, Idaho Code, may apply to reorganize by merging its policyholders' membership interests into a mutual insurance holding company by filing with the Director a joint application with the mutual insurance holding company complying with the provisions of this chapter. (7-1-99)

012. MERGERS OF MUTUAL INSURANCE HOLDING COMPANIES.

A mutual insurance holding company may apply to merge with another mutual insurance holding company by filing with the Director a plan of merger and complying with the provisions of Title 41, Chapter 38, Idaho Code. (7-1-99)

013. STOCK OFFERINGS.

01. Director's Prior Approval Required. No stock offering by a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company shall occur without the prior approval of the Director. The Director's approval may be obtained only through the application and hearing process described in this section. (7-1-99)

02. Application for Stock Offering. Every application for approval of a stock offering shall contain the following information: (7-1-99)

a. A description of the stock intended to be offered by the applicant, including a description of all shareholder rights; and (7-1-99)

b. The total number of shares authorized to be issued, the estimated number the applicant requests permission to offer, and the intended date or range of dates for the offer; and (7-1-99)

c. A justification for a uniform planned offering price or a justification of the method by which the offering price will be determined; and (7-1-99)

d. The name or names of any underwriter, syndicate member or placement agent involved and, if known, the name or names of each entity, person, or group of persons to whom the stock offering is to be made who will control five percent (5%) of the total outstanding class of shares, and the manner in which the offer is to be tendered. If any such entity or person is a corporation or business organization, the name of each member of its board of directors or equivalent management team shall be provided along with the name of each member of the board of directors of the offeror. Copies of any filings with the Securities and Exchange Commission disclosing intended acquisitions of the stock shall be included in the application; and (7-1-99)

e. A description of stock subscription rights to be afforded members of the mutual insurance holding company in conjunction with the stock offering; and (7-1-99)

f. A detailed description of all expenses to be incurred in conjunction with the stock offering; and (7-1-99)

g. An explanation of how funds raised by the stock offering are to be used; and (7-1-99)

h. Any other information requested by the Director. (7-1-99)

03. Required Provisions. No application regarding a planned stock offering shall be approved unless the plan contains provisions: (7-1-99)

a. Prohibiting officers, directors, and insiders of the mutual insurance holding company and its subsidiaries and affiliates from the purchase or ownership of shares of the stock offering, or issuance of stock options to or for the benefit of such officers, directors and insiders, for a period of at least six (6) months following the first date the offering was publicly and regularly traded. This paragraph shall not be construed to limit the rights of officers, directors and insiders from exercising subscription rights generally accorded members of the mutual insurance holding company, except that, pursuant to such subscription rights, the officers, directors, and insiders of

the mutual insurance holding company and its subsidiaries and affiliates may not purchase or own, in the aggregate, more than five percent (5%) of the stock offering for a period of at least six months following the first date the offering was publicly and regularly traded; and (7-1-99)

b. Requiring a majority of the members of the board of directors of the mutual insurance holding company to be persons who are not interested persons of the mutual insurance holding company or of an affiliated person of such company. The Director may waive this requirement upon a showing of good cause; and (7-1-99)

c. For the mutual insurance holding company to adopt articles of incorporation prohibiting any waiver of dividends from stock subsidiaries except under conditions specified in its articles of incorporation and after approval of the waiver by the board of directors of the mutual insurance holding company and the Director; and (7-1-99)

d. Requiring that, after the initial stock offering by an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary to a mutual insurance holding company, the boards of directors of each such insurance company or intermediate holding company include at least three directors who are not interested persons of the mutual insurance holding company; and (7-1-99)

e. Establishing, within the board of directors of the corporation offering stock, a pricing committee consisting exclusively of directors who are interested persons whose responsibility is to evaluate and approve the price of any stock offering. (7-1-99)

04. More Than One Class of Stock Allowed. An insurance company subsidiary of a mutual insurance holding company, an intermediate holding company subsidiary of a mutual insurance holding company, or an insurance company subsidiary of an intermediate holding company subsidiary to a mutual insurance holding company may issue more than one (1) class of stock provided, however, that at all times a majority of the voting stock is held by the mutual insurance holding company or its subsidiary and, provided further, that no class of common stock may possess greater dividend or other rights than the class held by the mutual insurance holding company or its subsidiary. (7-1-99)

05. Allowance for Experts. The Director may hire, at the applicant's expense, attorneys, actuaries, accountants, investment bankers and other experts as may reasonably be necessary to assist the Director in reviewing the application. (7-1-99)

06. Public Hearing. The Director may, at his discretion, hold a public hearing regarding any application for approval of a stock offering. Upon receipt of an application for approval of a stock offering which includes an initial offering of stock, the Director shall hold a public hearing at which all interested parties may appear and present evidence and argument regarding the applicant's planned offering. The Director shall provide the applicant adequate notice of the hearing, such that the applicant can provide notice of the hearing to members of the mutual insurance holding company, in manner approved by the Director, and not less than twenty (20) days prior to the hearing. Following the hearing, the Director may approve, conditionally approve, or deny the application. The Director may approve the plan if: (7-1-99)

a. The offering complies with these rules and other provisions of law; and (7-1-99)

b. The method for establishing the price of a stock offering is consistent with generally accepted market or industry practices for establishing stock offering prices in similar transactions; and (7-1-99)

c. The plan and offering will not unfairly impact the interests of members of the mutual insurance holding company. (7-1-99)

07. Concurrent Filing with SEC Allowed. None of the foregoing shall be deemed to prohibit the filing of a registration statement with the Securities and Exchange Commission prior to or concurrently with the giving of notice to the members. (7-1-99)

08. Subsequent Offerings of Publicly Traded Stock. (7-1-99)

a. Notwithstanding the provisions of Section 013 of this chapter, stock offerings which are not an initial stock offering, and which offer stock regularly traded on the New York Stock Exchange, the American Stock Exchange, or another exchange approved by the Director, or designated on the national association of securities dealers automated quotations - national market system (NASDAQ), may be sold in accordance with the following procedure: If a mutual insurance holding company, an insurance company subsidiary of a mutual insurance holding company, an intermediate holding company, or an insurance company subsidiary of an intermediate holding company intends to make a stock offering which would be governed by the provisions of this section, that entity shall deliver to the Director, not less than thirty (30) days prior to the offering, a notice of the planned stock offering and information regarding: (7-1-99)

- i. The total number of shares intended to be offered; and (7-1-99)
- ii. The intended date of sale; and (7-1-99)
- iii. Evidence the stock is regularly traded on one of the public exchanges noted above; and (7-1-99)
- iv. A record of the trading pace and trading volume of the stock during the prior fifty-two (52) weeks. (7-1-99)

b. The Director shall be deemed to have approved the sale unless, within thirty (30) days following receipt of such notice, the Director issues an objection to the sale. If the Director issues an objection to the sale, the procedures set forth in Subsection 013.02 of this chapter shall be followed to determine whether the Director approves of the proposed sale. (7-1-99)

09. Expiration of Approval of Stock Offering. Approval of a stock offering obtained under either Subsection 013.06 or 013.07 above shall expire ninety (90) days following the date of the approval or deemed approval, except as otherwise provided by order of the Director. (7-1-99)

10. Representation of Director's Approval Not Allowed. No prospectus, information, sales material or sales presentation by the applicant, or by any representative, agent or affiliate of the applicant, shall contain a representation that the Director's approval of a stock offering constitutes an endorsement of the price, price range, or any other information relating to the stock. (7-1-99)

014. PROHIBITED PRACTICES.

The following practices are prohibited: (7-1-99)

01. Borrowing Funds. Borrowing funds from the mutual insurance holding company, or its subsidiaries and affiliates, to finance the purchase of any portion of a stock offering. (7-1-99)

02. Payment of Commissions. Payment of commissions, "special fees" and any other special payments or extraordinary compensation to officers, directors, interested persons and affiliates, for arranging, promoting, aiding or assisting in reorganization to a mutual insurance holding company, or for arranging promoting, aiding assisting or participating in the structuring and placement of a stock offering. (7-1-99)

03. Avoidance of Provisions of Chapter. Entering into an understanding or agreement transferring legal or beneficial ownership of stock to another person in avoidance of this chapter. (7-1-99)

015. REGULATION OF HOLDING COMPANY SYSTEM.

01. Compliance with Provisions of Insurance Holding Company Law. A mutual insurance holding company, and its subsidiaries and affiliates, shall be subject to all provisions of Title 41, Chapter 38, Idaho Code, Holding Company Systems. In addition to the provisions of that chapter, all material transactions between subsidiaries and affiliates of the mutual insurance holding company, as defined by Title 41, Chapter 38, Idaho Code, must be approved by a majority of the directors of the mutual insurance holding company as being both fair and reasonable, and made on terms and conditions not less favorable than those available from unaffiliated third parties. (7-1-99)

02. Violations of Insurance Code. If the Director finds, after notice and hearing, that activities within a mutual insurance holding company system have violated provisions of Title 41, Idaho Code, have violated administrative procedures, or act to circumvent requirements or prohibitions contained in the Idaho Insurance Code or administrative rules, the Director may prohibit or order rescission of any transaction relating to those activities. (7-1-99)

016. REPORTING OF STOCK OWNERSHIP AND TRANSACTIONS.

01. Acquisition of Ownership Interest. Any director or officer of a mutual insurance holding company, its subsidiary or affiliate, who acquires directly or indirectly the beneficial ownership of any security issued by any member of the mutual insurance holding company system shall, within fifteen (15) days following the transaction, file with the Director a statement of the transaction in a format prescribed by the Director. (7-1-99)

02. Filing of SEC Forms with Department. A mutual insurance holding company, and its subsidiaries and affiliates, shall file with the Director, within fifteen (15) days of receipt, copies of Form 3, Form 4 and Schedule 13D, or any equivalent filings, such filings made under the Securities and Exchange Act of 1934, as amended. (7-1-99)

017. -- 999. (RESERVED)

**IDAPA 18
TITLE 07
CHAPTER 12**

18.07.12 – CORPORATE GOVERNANCE ANNUAL DISCLOSURE

000. LEGAL AUTHORITY.

This rule is promulgated pursuant to the authority granted by Title 41, Chapters 2 and 64, Idaho Code. (3-28-18)

001. TITLE AND SCOPE.

01. Title. This rule is titled IDAPA 18.07.12, “Corporate Governance Annual Disclosure.” (3-28-18)

02. Scope. This rule sets forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the director to carry out the provisions of Title 41, Chapter 64, Idaho Code. (3-28-18)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of this rule, or to the documentation of compliance with this rule. These documents will be available for public inspection and copying in accordance with the public records act. (3-28-18)

003. ADMINISTRATIVE APPEALS.

All administrative appeals will be governed by Title 41, Chapter 2, Idaho Code, and the Idaho Administrative Procedures Act, Title 67, Chapter 52, Idaho Code, and IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (3-28-18)

004. INCORPORATION BY REFERENCE.

The most recent National Association of Insurance Commissioners (NAIC) Financial Analysis Handbook (2016 Annual / 2017 Quarterly edition) is hereby incorporated by reference into IDAPA 18.07.12. Copies of this handbook, may be viewed at: (3-28-18)

01. Department. Idaho Department of Insurance, 700 West State Street, 3rd Floor, Boise, Idaho 83720-0043; (3-28-18)

02. NAIC Documents. NAIC Executive Headquarters, 2301 McGee Street, Suite 800 Kansas City, MO 64108-2662. NAIC website at http://www.naic.org/prod_serv_publications.htm. (3-28-18)

005. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS – WEB SITE.

01. Office Hours. 8 a.m. to 5 p.m. except Saturday, Sunday and legal holidays. (3-28-18)

02. Mailing Address. P.O. Box 83720, Boise, ID 83720-0043. (3-28-18)

03. Street Address. 700 West State Street, 3rd Floor, Boise, Idaho 83702-0043. (3-28-18)

04. Web Site Address. The department’s website is <http://www.doi.idaho.gov>. (3-28-18)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code, as well as applicable exemptions. (3-28-18)

007. – 009. (RESERVED)

010. DEFINITIONS.

The Idaho Department of Insurance adopts the definitions set forth in Section 41-6402, Idaho Code. In addition, the following terms are defined as used in this chapter. (3-28-18)

01. Director. The Director of the Department of Insurance. (3-28-18)

02. Senior Management. Any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer (CEO), chief financial officer (CFO), chief operations officer (COO), chief procurement officer (CPO), chief legal officer (CLO), chief information officer (CIO), chief technology officer (CTO), chief revenue officer (CRO), chief visionary officer (CVO), or any other chief or “C” level executive. (3-28-18)

011. FILING PROCEDURES.

01. Filing Deadline. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by chapter 64, title 41, Idaho Code, shall, no later than June 1 of each calendar year, submit to the director a CGAD that contains the information described in Section 012 of this rule. (3-28-18)

02. Signature. The CGAD must include a signature of the insurer’s or insurance group’s chief executive officer or corporate secretary attesting to the best of that individual’s belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer’s or insurance group’s board of directors (board) or the appropriate committee thereof. (3-28-18)

03. Format. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by this rule and is permitted to customize the CGAD to provide the most relevant information necessary to permit the director to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group. (3-28-18)

04. Providing Information. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer’s or insurance group’s risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting. (3-28-18)

05. Completion on Insurance Group Level. Notwithstanding Subsection 011.01, and as outlined in Section 41-6403, Idaho Code, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent financial analysis handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request. (3-28-18)

06. Referencing. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., Own Risk Solvency Assessment (ORSA) summary report, holding company form B or F filings, Securities and Exchange Commission (SEC) proxy statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in Section 012. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator. (3-28-18)

07. Filing of Amended Versions. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state. (3-28-18)

012. CONTENTS OF CORPORATE GOVERNANCE ANNUAL DISCLOSURE.

01. Detail. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices. (3-28-18)

02. GCAD Considerations. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following: (3-28-18)

a. The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and (3-28-18)

b. The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer (CEO) and chairman of the board within the organization. (3-28-18)

03. Factors. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors: (3-28-18)

a. How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group. (3-28-18)

b. How an appropriate amount of independence is maintained on the board and its significant committees. (3-28-18)

c. The number of meetings held by the board and its significant committees over the past year as well as information on director attendance. (3-28-18)

d. How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion should include, for example: (3-28-18)

i. Whether a nomination committee is in place to identify and select individuals for consideration. (3-28-18)

ii. Whether term limits are placed on directors. (3-28-18)

iii. How the election and re-election processes function. (3-28-18)

iv. Whether a board diversity policy is in place and if so, how it functions. (3-28-18)

e. The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any board or committee training programs that have been put in place). (3-28-18)

04. Additional Factors. The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors: (3-28-18)

a. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including: (3-28-18)

i. Identification of the specific positions for which suitability standards have been developed and a description of the standards employed. (3-28-18)

ii. Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes. (3-28-18)

b. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example: (3-28-18)

i. Compliance with laws, rules, and regulations; and (3-28-18)

ii. Proactive reporting of any illegal or unethical behavior. (3-28-18)

c. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the director to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example: (3-28-18)

i. The board's role in overseeing management compensation programs and practices. (3-28-18)

ii. The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid; (3-28-18)

iii. How compensation programs are related to both company and individual performance over time; (3-28-18)

iv. Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels; (3-28-18)

v. Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; (3-28-18)

vi. Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees. (3-28-18)

d. The insurer's or insurance group's plans for CEO and senior management succession. (3-28-18)

05. Oversight. The insurer or insurance group shall describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of: (3-28-18)

a. How oversight and management responsibilities are delegated between the board, its committees and senior management; (3-28-18)

b. How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks; (3-28-18)

c. How reporting responsibilities are organized for each critical risk area. The description should allow the director to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer: (3-28-18)

i. Risk management processes (An ORSA summary report filer may refer to its ORSA summary report pursuant to Chapter 63, Title 41, Idaho Code); (3-28-18)

ii. Actuarial function; (3-28-18)

iii. Investment decision-making processes; (3-28-18)

- iv. Reinsurance decision-making processes; (3-28-18)
 - v. Business strategy/finance decision-making processes; (3-28-18)
 - vi. Compliance function; (3-28-18)
 - vii. Financial reporting/internal auditing; and (3-28-18)
 - viii. Market conduct decision-making processes. (3-28-18)
- 013. – 999. (RESERVED)**

**IDAPA 18
TITLE 08
CHAPTER 01**

18.08.01 – ADOPTION OF THE INTERNATIONAL FIRE CODE

000. LEGAL AUTHORITY.

These rules are promulgated and adopted pursuant to the authority vested in the Director under Title 41, Chapter 2, Idaho Code. (7-1-99)

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 18.08.01, Rules of the Idaho Department of Insurance, Title 01, Chapter 50, “Adoption of the International Fire Code.” (4-7-11)

02. Scope. Pursuant to the authority provided by Section 41-253, Idaho Code, the State Fire Marshal hereby adopts the 2000 edition of the International Fire Code, with appendices thereto, and such later editions that may be so published and adopted by the State Fire Marshal, as the minimum standard for the protection of life and property from fire and explosion in the state of Idaho. All such later editions, and appendices thereto, shall be adopted in accordance with Section 67-5229, Idaho Code. (4-7-11)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost in the main office and each regional or district office of this agency. (7-1-99)

003. ADMINISTRATIVE APPEALS.

Any administrative appeal regarding this chapter should be made in accordance with Chapter 2, Title 41, Idaho Code, and to the extent not in conflict therewith, Chapter 52, Title 67, Idaho Code, as well as IDAPA 04.11.01, “Idaho Rules of Administrative Procedure of the Attorney General.” (5-3-03)

004. INCORPORATION BY REFERENCE.

01. 2015 International Fire Code. In accordance with Section 67-5229, Idaho Code, and pursuant to the authority provided by Section 41-253, Idaho Code, the State Fire Marshal hereby adopts the 2015 edition of the International Fire Code as published by the International Code Council. Any revisions, additions, deletions and/or appendices to the 2015 International Fire Code are included herein. (3-29-17)

02. Availability of Referenced Material. Copies of the 2015 edition of the International Fire Code are available for public inspection at the office of the State Fire Marshal. The 2015 International Fire Code and supplements thereto may be purchased by writing the International Code Council, 25442 Network Place, Chicago, Illinois 60673 or online through the electronic store on the Council’s website at <http://www.iccsafe.org>. (3-29-17)

005. OFFICE – OFFICE HOURS, MAILING ADDRESS AND STREET ADDRESS.

The office of the State Fire Marshal is located at 700 West State Street, third floor, Boise Idaho. The business hours are 8 am through 5 pm, Monday through Friday. The mailing address is State Fire Marshal, Department of Insurance, P.O. Box 83720, Boise, ID 83720-0043. The department’s website is <http://www.doi.idaho.gov>. (4-7-11)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with this rule are subject to the provisions of the Idaho Public records Law, Title 74, Chapter 1, Idaho Code. (4-7-11)

007. -- 009. (RESERVED)

010. CONSTRUCTION AND DESIGN PROVISIONS, SECTION 102.1, INTERNATIONAL FIRE CODE.

Delete Item No. 3 of Section 102.1, International Fire Code. (5-3-03)

011. DEPARTMENT OF FIRE PREVENTION, SECTION 103.2 -- APPOINTMENTS, INTERNATIONAL FIRE CODE.

Delete the following language in section 103.2 of the International Fire Code: "... and the fire code official shall not be removed from office except for cause and after full opportunity to be heard on specific and relevant charges by and before the appointing authority." (3-20-14)

012. GENERAL AUTHORITY AND RESPONSIBILITIES, SECTION 104.1, INTERNATIONAL FIRE CODE.

Add the following second paragraph to Section 104.1, General, International Fire Code: (5-3-03)

01. Fire Chief's Authority. The fire chief is authorized to administer and enforce this code. Under the chief's direction, the fire department is authorized to enforce all ordinances of the jurisdiction pertaining to: (5-3-03)

- a. The prevention of fires; (5-3-03)
- b. The suppression or extinguishment of dangerous or hazardous fires; (5-3-03)
- c. The storage, use and handling of hazardous materials; (5-3-03)
- d. The installation and maintenance of automatic, manual and other private fire alarm systems and fire- extinguishing equipment; (5-3-03)
- e. The maintenance and regulation of fire escapes; (5-3-03)
- f. The maintenance of fire protection and the elimination of fire hazards on land and in buildings, and other property, including those under construction; (5-3-03)
- g. The maintenance of means of egress; and (5-3-03)
- h. The investigation of the cause, origin and circumstances of fire and unauthorized releases of hazardous materials, for authority related to control and investigation of emergency scenes, see Section 104.11. (5-3-03)

013. -- 015. (RESERVED)

016. PERMIT REQUIRED, SECTION 105.1.1, INTERNATIONAL FIRE CODE.

Delete "the required permit" from the last sentence of Section 105.1.1 of the International Fire Code and add "a permit if required by the authority having jurisdiction." (3-20-14)

017. VIOLATION PENALTIES, SECTION 109.4, INTERNATIONAL FIRE CODE.

In the first sentence of Section 109.4 of the International Fire Code, delete "[SPECIFY OFFENCE], punishable by a fine of not more than [AMOUNT] dollars, or by imprisonment not exceeding [NUMBER OF DAYS], or both such fine and imprisonment" and add the word "misdemeanor". (3-20-14)

018. FAILURE TO COMPLY, SECTION 111.4, INTERNATIONAL FIRE CODE.

In Section 111.4, International Fire Code, delete this entire section. (5-3-03)

019. SECTION 202, INTERNATIONAL FIRE CODE.

01. Fire Code Official. Add "or as appropriate the Idaho State Fire Marshal" to the end of the definition for FIRE CODE OFFICIAL in Section 202 of the International Fire Code. (3-29-17)

02. Driveway. Add "DRIVEWAY. A vehicular ingress and egress route that serves no more than five (5) single family dwellings, not including accessory structures." (3-29-17)

03. Fire Station. Add "FIRE STATION, A building, or portion of a building that provides, at a

minimum, all weather protection for fire apparatus. Temperatures inside the building used for this purpose must be maintained at above thirty-two (32) degrees Fahrenheit.” (3-29-17)

020. SKY LANTERNS, SECTION 308.1.6.3, INTERNATIONAL FIRE CODE.

01. Untethered Sky lanterns. To section 308.1.6.3 delete the sentence: “A person shall not release or cause to be released an untethered sky lantern.” (3-29-17)

02. Sky lantern permit. To section 308.1.6.3 add the following: “A person shall not release or cause to be released a sky lantern, tethered or untethered without obtaining a permit, if required by the fire code or jurisdiction. When, in the opinion of the fire code official, the release of sky lanterns, tethered or untethered, constitutes a danger to persons or property, based on the current weather conditions, knowledge of topography, vegetation, or any other reasonable factor, is authorized to require additional safeguards prior to the release of sky lanterns. The fire code official may suspend, revoke, postpone, or prohibit the release of any sky lantern at any time.” (3-29-17)

021. CHAPTER 5 FIRE SERVICE FEATURES.

Make the following changes within Chapter 5 of the International Fire Code; (3-20-14)

01. Section 501. (4-7-11)

a. To section 501.3 after the phrase, Construction documents for proposed, add the word “driveways.” (4-7-11)

b. To section 501.4 after the phrase, When fire apparatus access roads, add the word “driveways.” (4-7-11)

02. Section 502. (3-29-17)

a. To section 502, add the following word “DRIVEWAY.” (3-29-17)

b. To section 502, add the words “FIRE STATION.” (3-29-17)

03. Section 503. (4-7-11)

a. To section 503 add the words, “AND DRIVEWAYS” to the section heading. (4-7-11)

b. To section 503.1.1 add the following sentence, “Driveways shall be provided and maintained in accordance with Sections 503.1.1 through 503.13.” (3-29-17)

c. To section 503.6 delete the sentence, The installation of security gates across a fire apparatus access road shall be approved by the fire chief. (4-7-11)

d. Add the following section, “503.7 Driveways. Driveways shall be provided when any portion of an exterior wall of the first story of a building is located more than 150 feet (45720mm) from a fire apparatus access road. Driveways shall provide a minimum unobstructed width of 12 feet (3658mm) and a minimum unobstructed height of 13 feet 6 inches (4115mm). Driveways in excess of 150 feet (45720mm) in length shall be provided with turnarounds. Driveways in excess of 200 feet (60960mm) in length and less than 20 feet (6096mm) in width may require turnouts in addition to turnarounds.” (4-7-11)

e. Add the following section, “503.7.1 Limits. A driveway shall not serve in excess of five single family dwellings.” (4-7-11)

f. Add the following section, “503.7.2 Turnarounds. Driveway turnarounds shall have an inside turning radius of not less than 30 feet (9144mm) and an outside turning radius of not less than 45 feet (13716mm). Driveways that connect with an access road or roads at more than one point may be considered as having a turnaround if all changes of direction meet the radius requirements for driveway turnarounds.” (4-7-11)

g. Add the following section, “503.7.3 Turnouts. Where line of sight along a driveway is obstructed by a man-made or natural feature, turnouts shall be located as may be required by the fire code official to provide for safe passage of vehicles. Driveway turnouts shall be of an all-weather road surface at least 10 feet (3048mm) wide and 30 feet (9144mm) long.” (4-7-11)

h. Add the following section, “503.7.4 Bridge Load Limits. Vehicle load limits shall be posted at both entrances to bridges on driveways and private roads. Design loads for bridges shall be established by the fire code official.” (4-7-11)

i. Add the following section, “503.7.5 Address markers. All buildings shall have a permanently posted address, which shall be placed at each driveway entrance and be visible from both directions of travel along the road. In all cases, the address shall be posted at the beginning of construction and maintained thereafter. The address shall be visible and legible from the road on which the address is located. Address signs along one-way roads shall be visible from both the intended direction of travel and the opposite direction. Where multiple address’s are required at a single driveway, they shall be mounted on a single post, and additional signs shall be posted at locations where driveways divide.” (4-7-11)

j. Add the following section, “503.7.6 Grade. The gradient for driveways shall not exceed 10 percent unless approved by the fire code official.” (4-7-11)

k. Add the following section, “503.7.7 Security Gates. Where security gates are installed, they shall have an approved means of emergency operation. The security gates and emergency operation shall be maintained operational at all times.” (4-7-11)

l. Add the following section, “503.7.8 Surface. Driveways shall be designed and maintained to support the imposed loads of local responding fire apparatus and shall be surfaced as to provide all weather driving capabilities.” (4-7-11)

04. Section 507. To section 507.2 Type of water supply. delete the existing language and add the following, “A water supply shall consist of water delivered by fire apparatus, reservoirs, pressure tanks, elevated tanks, water mains or other sources approved by the fire code official capable of providing the required fire flow. Exception. The water supply required by this code shall only apply to structures served by a municipal fire department or a fire protection district and within ten miles (16093m) of a responding fire station.” (4-7-11)

022. -- 026. (RESERVED)

027. ALTERNATIVE AUTOMATIC FIRE-EXTINGUISHING SYSTEMS, SECTION 904.1.1, INTERNATIONAL FIRE CODE.

Add the following language to the beginning of section 904.1.1 of the International Fire Code, “If required by the authority having jurisdiction,”. (3-29-17)

028. PORTABLE FIRE EXTINGUISHERS, SECTION 906.2.1, INTERNATIONAL FIRE CODE.

Add the following language to the beginning of section 9.6.2.1 of the International Fire Code, “If required by the authority having jurisdiction,”. (3-20-14)

029. -- 036. (RESERVED)

037. FIRE ALARM AND DETECTION SYSTEMS, SECTION 907.1, INTERNATIONAL FIRE CODE.

Notification Devices. When fire alarm systems not required by the International Fire Code are installed, the notification devices shall meet the minimum design and installation requirements for systems which are required by this code. Intent: (Non-required fire alarm systems shall provide the same level of occupant notification that required systems provide). (5-3-03)

038. CONSTRUCTION REQUIREMENTS FOR EXISTING BUILDINGS, SECTION 1101.1, INTERNATIONAL FIRE CODE.

Add the following language to the end of section 1101.1 of the International Fire Code, “only, if in the opinion of the

fire code official, they constitute a distinct hazard to life or property.” (3-20-14)

039. -- 040. (RESERVED)

041. EXPLOSIVES AND FIREWORKS, CHAPTER 56, INTERNATIONAL FIRE CODE.

Delete Sections 5601.1.3, 5601.2.2, 5601.2.3, 5601.2.4.1, 5601.2.4.2, and sections 5608.2, 5608.2.1, and 5608.3 of the International Fire Code. (3-20-14)

042. -- 045. (RESERVED)

046. UNDERGROUND TANKS OUT OF SERVICE FOR ONE YEAR, SECTION 5704.2.13.1.3 INTERNATIONAL FIRE CODE.

Add to Section 5704.2.13.1.3, International Fire Code, the following paragraph: Upon approval of the Chief underground tanks that comply with the performance standards for new or upgraded underground tanks set forth in Title 40 Section 280.20 or 280.21 of the Code of Federal Regulations may remain out of service indefinitely so long as they remain in compliance with the operation, maintenance and release detection requirements of the federal rule. (3-20-14)

047. -- 051. (RESERVED)

052. REFERENCED STANDARDS, CHAPTER 80, INTERNATIONAL FIRE CODE.

Beginning on Page 439, of the NFPA Referenced Standards, make the following changes to the listed editions:

Delete	Add	Delete	Add
2-2011	2-2016	105-2013	105-2016
11-2010	11-2016	110-2013	110-2016
13-2013	13-2016	111-2013	111-2016
13D-2013	13D-2016	160-2011	160-2016
13R-2013	13R-2016	170-2012	170-2015
14-2013	14-2016	211-2013	211-2016
20-2013	20-2016	265-2011	265-2015
24-2013	24-2016	303-2011	303-2016
30-2012	30-2015	318-2012	318-2015
31-2011	31-2016	326-2010	326-2015
32-2011	32-2016	400-2013	400-2016
35-2011	35-2016	409-2011	409-2016
40-2011	40-2016	410-2010	410-2015
55-2013	55-2016	701-2010	701-2015
56-2012	56-2014	750-2014	750-2015
59A-2013	59A-2016	914-2010	914-2015
72-2013	72-2016	1126-2011	1126-2016

Delete	Add	Delete	Add
80-2013	80-2016		

(3-29-17)

053. -- 055. (RESERVED)

056. REFERENCES TO APPENDIX, INTERNATIONAL FIRE CODE.

When this code references the appendix, the provisions of the appendix shall not apply unless specifically incorporated by reference. The following appendixes of the International Fire Code are incorporated by reference: (5-3-03)

01. Appendix B, Fire Flow Requirements for Buildings. (5-3-03)

02. Appendix C, Fire Hydrant Location and Distribution. (5-3-03)

03. Appendix D, Fire Apparatus Access Roads. (4-2-08)

a. To section D101.1 Scope, add the following sentence, “Driveways as described in section 503.7 through 503.11 are not subject to the requirements of this appendix.” (4-7-11)

b. To section D102.1, after the phrase, by way of an approved fire apparatus access road, add the following “designed and maintained to support the imposed loads of the responding fire apparatus and shall be surfaced so as to provide all-weather driving capabilities.” And delete the remainder of the section. (4-7-11)

c. To section D103.2 Grade. Add the following. “The gradient of the fire apparatus access road shall be within the limits established by the fire code official based on the capabilities of the responding fire departments apparatus.” Delete the remainder of the section and the exception. (4-7-11)

04. Appendix E, Hazard Categories. (5-3-03)

05. Appendix F, Hazard Rankings. (5-3-03)

057. -- 999. (RESERVED)