CHAPTER 3, LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

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28 TAC §§3.9202, 3.9203, 3.9206, 3.9211, and 3.9212

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28 TAC §3.9401 and §3.9403

SUBCHAPTER NN. CONSUMER NOTICES FOR LIFE INSURANCE POLICY AND ANNUITY CONTRACT REPLACEMENTS
28 TAC §3.9503

INTRODUCTION. The Commissioner of Insurance adopts amendments to 28 TAC Chapter 3, concerning life, accident, and health insurance and annuities. Sections 3.2 - 3.4, 3.6, 3.7, 3.104, 3.105, 3.107, 3.108, 3.114, 3.115, 3.124, 3.127, 3.203 - 3.205, 3.301, 3.302, 3.308, 3.310, 3.311, 3.408, 3.601, 3.702, 3.704, 3.802 - 3.806, 3.811, 3.909, 3.1001, 3.1002, and 3.1006, 3.1101, 3.1303 - 3.1305, 3.1403, 3.1404, 3.1601, 3.1602, 3.1605, and 3.1607, 3.1720, 3.1740, 3.1742, 3.1760, 3.3001, 3.3009, 3.3010, 3.3038, 3.3039, 3.3052, 3.3057, 3.3070, 3.3092, 3.3100, 3.3101, 3.3110, 3.3321, 3.3401 - 3.3403, 3.3829, 3.3832, 3.3837, 3.3842, 3.3849, 3.3871, 3.3873, 3.3874, 3.4001, 3.4002, 3.4004, 3.4005, 3.4101 - 3.4103 and 3.4105, 3.4317, 3.4503, 3.4506, 3.5103, 3.5302, 3.5602, 3.5610, 3.9101, 3.9103, 3.9104, 3.9106, 3.9202, 3.9203, 3.9206, 3.9211, 3.9212, 3.9401, 3.9403 and 3.9503 are adopted without changes to the proposed text published in the November 5, 2021, issue of the *Texas Register* (46 TexReg 7496).

Section 3.5002 and §3.1606 are adopted with nonsubstantive changes to the proposed text. The Texas Department of Insurance (TDI) revised §3.5002 to correct internal references to other rule sections by replacing "subchapter" with "title" in

§3.5002(9) and §3.5002(17) and by adding a missing end parenthesis in §3.5002(7)(E). TDI revised §3.1606 by changing the words "apply" to "applies" and "remain" to "remains."

REASONED JUSTIFICATION. The amendments update numerous sections throughout Chapter 3 to reflect Insurance Code §1105.0015 and §425.073, relating to the valuation manual and the operative date of that manual. The amendments also correct and update obsolete and incorrect text throughout Chapter 3. Amendments include updates to (1) statutory references to reflect Insurance Code recodification; (2) use the current names of state agencies; (3) specify current mailing and website addresses; and (4) correct punctuational, grammatical, and typographical errors and revise punctuation and capitalization as appropriate for agency style.

Amendments to multiple sections include the deletion of "shall" or replacement of "shall" with "will" (or another context-appropriate word). The purpose of changing the word "shall" is to provide plain language clarification of the rule text, consistent with current agency style and guidance on the TDI website, which provides links to resources on writing in plain language. Resources TDI uses for plain language guidance include plainlanguage.gov, which provides federal plain language guidelines, and the National Archives guidelines for clear legal documents. Both sources advise using alternatives to the word "shall" to provide clarity for readers.

The adopted sections also replace "subchapter" or "chapter" with "title" where necessary, and remove "the" in front of and commas following "Insurance Code" where appropriate. The adopted sections also replace gendered references to the Commissioner with the phrase "the commissioner."

SUMMARY OF COMMENTS. TDI did not receive any comments on the proposed amendments.

SUBCHAPTER A. SUBMISSION REQUIREMENTS FOR FILINGS AND DEPARTMENTAL ACTIONS RELATED TO SUCH FILINGS
28 TAC §§3.2 - 3.4, 3.6, and 3.7

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter A under Insurance Code §§1153.005, 1251.008, 1273.005, 1701.060, and 36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §1251.008 states that the Commissioner may adopt rules necessary to administer Chapter 1251.

Insurance Code §1273.005 specifies that the Commissioner may adopt rules to implement Chapter 1273, Subchapter A.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.2. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Alternate face page--A face page of a group policy, certificate, or contract, which may be used in place of the face page of a previously approved or exempted group policy, certificate, or contract when the group policy, certificate, or contract will be issued to a different or specific group (e.g., a policy that was filed as an "ABC Multiple Employer Trust (MET)" that is later issued to a specific MET).

(2) Department--The Texas Department of Insurance.

(3) Filing--A submission, made to the department by a company, that is accompanied by either a transmittal checklist or a transmittal form, and which may include policies, certificates, contracts, applications, certifications, informational materials, insert pages, riders, limited partial refilings, matrix filings, and rates.

(4) General use--A filing that will be used with other forms submitted in the filing or with previously approved and exempted forms for a certain product or products or a subset of a product or type (e.g., an application that will be used with all life products; an application that will be used with all universal life products; an application that will be used with group life and accident and health products; an application that will be used with major medical and hospital surgical products).

(5) Insert page--A page used to replace an existing page of a previously approved or exempted contract.

(6) Limited, partial refilings--A change to a previously approved or exempted life or annuity form that meets one or more of the criteria set forth in subparagraphs (A) - (D) of this paragraph as follows:

(A) a change in the text, interest rate, guaranteed charges, or mortality table used to compute nonforfeiture values for life insurance or annuities;

(B) a change in the current interest rate, where such rates are guaranteed and shown in the policy or contract;

(C) a change in the reserves (if the change in reserves impacts the text of the policy);

(D) a change to the separate account for variable products when the separate account is bracketed as variable text on the initial filing.

(7) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, allowing the flexibility to create multiple policies,

certificates, contracts or applications by using numerous combinations of the individual provisions approved or exempted.

(8) New filing--A filing that has not been previously reviewed, approved, or disapproved by the department, or a filing that has been previously withdrawn and is being resubmitted as a new filing (not to include the withdrawal of a filing containing corrections to a form subsequent to the company receiving a disapproval from the department);

(9) Purpose and use--For each submitted form, the purpose and use will be a brief description to include at least the following:

(A) how a form will be used (e.g., the application will be used on a general use basis; or used with specific policy(ies) or contract form(s) previously approved or exempted);

(B) the type of coverage provided by the form (e.g., whole life, term life, universal life, variable annuity, major medical, specified disease, accident only, or hospital indemnity);

(C) any key or unique provisions contained in the form (e.g., for life and annuities--bonus interest, additional interest credits, two-tier values, bail-out, market value adjustments, and long term care; for accident and health--preferred provider benefits, prescription drugs, and innovative benefit in a Medicare supplement policy);

(D) if applicable, how the form will be marketed (e.g., direct, agent, or electronic);

(E) if applicable, to whom the form is to be marketed (e.g., specific groups such as an annuity contract marketed to issue ages 25 - 60, or a health benefit plan issued to children only, including Insurance Code Chapter 1502).

(10) Rider--An amendment or endorsement that changes a policy, certificate, or contract to add, expand, limit, or remove provisions and/or benefits, which

may be optional or mandatory, and when used, becomes a part of the policy, certificate, or contract.

§3.3. Transmittal Information.

(a) All filings submitted pursuant to this subchapter must be accompanied by the department's transmittal checklist except for the documents listed in §3.1(11)(B) of this title (relating to Scope), which must be accompanied by the department's transmittal form as described in this section. Copies of the transmittal checklist and transmittal form are available from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department's website at www.tdi.texas.gov/forms.

(b) The transmittal checklist must:

(1) provide complete and accurate information about the filing;

(2) include, at a minimum, the following information:

(A) the name and address of the submitting company;

(B) the contact person information as required in §3.4(b) of this title (relating to General Submission Requirements);

(C) the unique identifying form number of each form submitted;

(D) an explanation of the purpose and use of each form as defined in §3.2 of this title (relating to Definitions);

(E) an indication of the product and type;

(F) an indication of whether the filing is prompted by a business change such as an assumption, a name change, or a demutualization/conversion;

(G) the applicable authority from the Insurance Code or the Administrative Code under which the form is being submitted as described in §3.5 of this title (relating to Filing Authorities and Categories);

(H) an indication of whether the filing is a matrix filing;

(I) rate filing information, if applicable;

(J) a statement that the submission will be used:

(i) on a general use basis, only with the policy being filed, or with previously approved or exempted forms; and

(ii) if the submission will be used with previously approved or exempted forms, a listing of the following:

(I) the form numbers of the previously approved or exempted forms;

(II) the approval or exemption dates of the previously approved or exempted forms; and

(III) a brief description of when or how each submitted form will be used with the previously approved or exempted forms;

(K) if the filing is a group filing, it must contain:

(i) A statement specifying the specific group type as set forth in §3.6(c)(1) of this title (relating to Certifications, Attachments, and Additional Information Requirements).

(ii) A separate policy and certificate for each type of group. A submission of a single policy and certificate for use with more than one type of group is prohibited.

(iii) The following as applicable:

(I) a statement specifying the size of the group if issued under Chapter 26 of this title (relating to Small Employer Health Insurance Regulations);

(II) a copy of the trust agreement if issued to a trust;

(III) a copy of the constitution, bylaws, and articles of incorporation if issued to an association; or

(IV) certification and evidence that the master policy for the group was lawfully issued and delivered in a state in which the company was authorized to do insurance business;

(L) any certifications and attachments, including summary of differences, if applicable, or any additional information required by §3.6 of this title, or variable information in accordance with §3.4(e) of this title.

(3) be completed, signed, and certified by an attorney licensed to practice law in this state, an actuary familiar with the requirements of the Insurance and Administrative Codes, the chief executive officer of the filing company, or a person with authority to bind the company.

(c) The transmittal form must:

(1) provide complete and accurate information about the filing;

(2) include, at a minimum, the following information:

(A) the name and address of the submitting company;

(B) the contact person information as required by §3.4(b) of this title;

(C) an identification of the type of miscellaneous document or information being submitted as described in §3.1(11)(B) of this title; and

(D) for filings to be used with previously approved or exempted forms:

(i) the form numbers of the previously approved or exempted forms;

(ii) the approval or exemption dates of the previously approved or exempted forms;

(iii) a general statement of the types of previously approved or exempted forms (e.g., waiver of surrender charge rider); and

(iv) a brief description of when or how each submitted form will be used with the previously approved or exempted forms;

(d) Notwithstanding subsections (b)(2) and (c)(2) of this section, the commissioner may prescribe a transmittal document prescribed by the NAIC for purposes of standardization.

(e) Filings that are not accompanied by a completed transmittal checklist or transmittal form, or which do not include all required certifications or signatures will not be accepted by the department and will be returned to the company as incomplete.

§3.4. General Submission Requirements.

(a) Submission. Companies must submit one copy of the filing to the Life and Health Division at the address set forth in §3.3(a) of this title (relating to Transmittal Information). A filing submitted electronically must be submitted in such form and format as determined by the department.

(b) Contact person. A company submitting a filing to the department must:

(1) have one person designated as the contact person for that filing;

(2) provide the contact person's name, address, telephone number, and if available, email address on the transmittal checklist or transmittal form;

(3) provide, for any filing submitted by anyone other than the company, a dated letter of specific authorization which must:

(A) designate the consulting firm, actuary, legal counsel, or other person as the designated contact person for that filing; and

(B) be signed by an officer of the company or a person with authority to bind the company; and

(4) notify the department immediately of any change of information with regard to the contact person for a pending filing, regardless of whether the contact person is the company's employee or other authorized representative.

(c) Form specifications. Any filing submitted pursuant to this subchapter must comply with the following:

(1) Filings submitted in paper format must:

(A) be submitted on 8 1/2-by-11-inch paper;

(B) not be submitted in bound booklets;

(C) be legible;

(D) be in typewritten, computer generated, or printer's proof format; and

(E) not contain any color highlighting.

(2) Any form submitted must be designated by a form number that:

(A) is sufficient to distinguish it from all other forms used by the company;

(B) is located in the lower left-hand corner of the cover page or on the first page of the form if the form number is visible with the cover closed;

(C) has the additional identifying form number requirements set forth in Subchapter FF of this chapter (relating to Credit Life and Accident and Health Insurance), if the form is submitted for consideration pursuant to Insurance Code Chapter 1153; and

(D) has the additional identifying form number requirements set forth in §26.14(g) of this title (relating to Coverage), if the form is submitted for consideration pursuant to Insurance Code Chapter 1501.

(d) Specimen language and specimen fill-in material.

(1) For all forms, specimen language and fill-in material must reflect the most restrictive option available under variability. Additional descriptions of variability options must be provided upon request or as otherwise required.

(2) Life and annuity forms must be completed with fill-in material for specimen age 35. If the form is not issued at age 35, the fill-in material should be completed for the youngest age at which the form may be issued. If reduced death benefits are provided for any age at issue, the specimen form must be filled in for the age at issue for which the greatest reduction in benefits is made. The fill-in material must be for the longest premium paying period available under the form.

(e) Variable material.

(1) For all forms, any variable material in a form must be bracketed and contain a clear explanation of how the material will vary. It is acceptable for certain materials to vary due solely to the age, sex, classification of the insured, plan type such as 403(b) and IRA, telephone numbers, and addresses, depending on the manner in which the company intends to use the variations. The unique form number on a form may not be bracketed as variable.

(2) For individual life forms, the text and specifications of nonforfeiture assumptions generally cannot be considered variable material.

(f) Matrix filings. Policies, certificates, contracts, or applications may be submitted as a matrix filing. Any company submitting a matrix filing:

(1) must identify each provision with a unique form number that:

(A) is sufficient to distinguish it from all other provisions used by the company; and

(B) is located at the lower left-hand corner of the provision;

(2) may use the same provision filed under one form number for all products, provided the language is applicable to each product; however, any changes in

the language to comply with the requirements for each product will require a unique form number;

(3) must list the form number for each provision on the transmittal checklist and provide a statement indicating how the provision will be used and the type of product for which the provision will be used; and

(4) must provide the certifications required in §3.6(a)(8) of this title (relating to Certifications, Attachments, and Additional Information Requirements).

(g) Insert page filings. Policies, certificates, and contracts may be submitted with insert pages, or an insert page may be filed subsequent to the approval of a policy, certificate, or contract. Any company submitting an insert page filing:

(1) must identify each insert page with a unique form number that:

(A) is sufficient to distinguish it from all other forms used by the company; and

(B) is located in the lower left-hand corner of the page;

(2) may use the same insert page filed under one form number for all products, provided the language is applicable to each product type; however, any changes in the language to comply with the requirements for each product type will require a unique form number;

(3) may use the same insert page to replace an existing page of a previously approved or exempted contract; if used in this manner, the replaced page, as originally filed, must reflect a unique form number that distinguishes it from the other pages of the form or contract;

(4) must list the form number for each insert page on the transmittal checklist and provide a statement indicating how the insert page will be used and the type of product for which the insert page will be used; and

(5) must provide the certifications required in §3.6(a)(8) of this title.

(h) Limited, partial refilings. Limited, partial refilings must contain the change and any additional actuarial information necessary for a comprehensive review of the filing(s).

(i) Outline of coverage. An outline of coverage must be filed with each individual accident and health policy, group or individual Medicare supplement policy and/or certificate, or group or individual long-term care policy and/or certificate.

(j) Supplemental coverages.

(1) Individual accident and health forms submitted pursuant to §3.3080 of this title (relating to Supplemental Coverage) must be accompanied by the certification required in §3.6(a)(7) of this title;

(2) Group life forms submitted pursuant to Insurance Code §1131.051 or §1131.053 must be accompanied by the certification required in §3.6(a)(7) of this title.

(k) Complete submission of policy or contract forms. For a submission to be considered complete, the submission must include the following:

(1) the toll-free notice unless the company is exempt under §1.601(c) of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures) or has on file a toll-free notice which is current with the requirements set forth in §1.601 of this title;

(2) the application, if applicable;

(3) in the case of group policies or contracts, the certificate;

(4) any rider which will or can be included in all issues of the form; and

(5) disclosures and other information, if applicable.

(l) Riders included with filing. For any rider included with the policy or contract filing, indicate whether the rider is to be used:

(1) only with the policy being filed; or

(2) with other clearly identified previously approved or exempted forms.

(m) Previously approved or exempted forms. Any previously approved or exempted form (e.g., application or rider) to be used with the policy or contract filing need not be resubmitted; however, the filing must indicate the type of form (e.g., rider, policy, application, etc.), form number, and the approval or exemption date of the previously approved or exempted form. If there is a change in the use of the previously approved or exempted form, the filing must state the form number of the form(s) with which the previously approved or exempted form was designed to be exclusively used, as well as the updated forms list.

(n) Appropriate use of previously approved or exempted forms. The company is responsible for assuring the appropriate use of previously approved or exempted forms. This includes the appropriate use of any riders or other forms such as matrix and insert pages.

(o) Submission of a certificate for policies or contracts issued outside of Texas. A copy of the master policy or contract issued outside of Texas must accompany any life, annuity, credit, or accident and health certificate filed for review or filed as exempt, along with certification and evidence that the master policy for the group was lawfully issued and delivered in a state in which the company was authorized to do insurance business.

(p) Rates. Initial and subsequent rate filings must include all specific descriptions and required information as follows:

(1) policy forms for which the rate filing applies must be specified on the transmittal checklist or the transmittal form, as applicable;

(2) credit life and credit accident and health filings submitted under Insurance Code Chapter 1153 and Subchapter FF of this chapter must include the rate information;

(3) group and individual Medicare supplement filings submitted under Insurance Code §1652.101 and Subchapter T of this chapter (relating to Minimum

Standards for Medicare Supplement Policies) must include the applicable rate schedule and experience by plan;

(4) group and individual long-term care forms submitted under Insurance Code Chapter 1651 and Chapter 3, Subchapter Y of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies) must include the rate schedule;

(5) all individual accident and health filings submitted under Insurance Code Chapter 1701 must include the rate schedule; and

(6) rate schedules submitted must be accompanied by the actuarial information set forth in subsection (q) of this section.

(q) Actuarial information.

(1) Each life filing, including riders, insert pages, or limited partial refilings, which changes the nonforfeiture values of a particular policy or certificate must be accompanied by the information set forth in subparagraphs (A) - (C) of this paragraph:

(A) The mathematical formulas and sample calculations for the items set forth in clauses (i) - (iv) of this subparagraph.

(i) net premiums for the specimen age and plan of insurance;

(ii) specimen nonforfeiture calculations necessary to verify consistency between the nonforfeiture values and the text of the form for years one, 20, and 50;

(iii) terminal reserves for the specimen age and plan; and

(iv) any other calculations necessary to verify nonforfeiture values and reserves.

(B) An actuarial memorandum as specified in clauses (i) and (ii) of this subparagraph, as applicable:

(i) for universal life and interest sensitive forms:

(I) an actuarial memorandum must provide the mortality table, guaranteed interest rates, maximum surrender charges, maximum expense charges, maximum risk rates (cost of insurance rates), maximum loads, and maximum fees at issue. Upon a change in basic coverage, bands and risk classes for all ages must be provided.

(II) actuarial proof must be provided that:

(-a-) cash surrender values meet the minimum requirements of Insurance Code Chapter 1105;

(-b-) cash surrender values will always equal or exceed the minimum values required by law; and

(-c-) provide a comparison table of all guaranteed cash surrender values, standard nonforfeiture law minimum cash surrender values, guaranteed death benefits, and reserves. Such comparison should be based on the fill-in issue age (usually age 35) as defined in subsection (d) of this section, a premium which will provide coverage to the latest available maturity date, the minimum issue amount, minimum guaranteed interest rates, maximum guaranteed cost of insurance rates (mortality rates), maximum guaranteed charges, and a month-by-month calculation of the values shown in the comparison for the first and fiftieth years.

(ii) for variable life forms, actuarial information must be provided as required by §3.804 of this title (relating to Insurance Contract and Filing Requirements), and as required by this section.

(C) A statement must be provided certifying that all policies or certificates, in addition to the specimen language and fill-in material, will have premiums, reserves, and nonforfeiture values calculated in a manner consistent with the information furnished with the specimen language and fill-in material. Any qualifications to such

certification must be specified, including any variation in formulas at different ages at issue or at time of a change.

(2) For each annuity filing, an actuarial memorandum must be provided to meet the minimum requirements of Insurance Code Chapter 1107 and specify the guaranteed interest rates, the maximum surrender charges, and any other maximum charges applicable in the determination of nonforfeiture values. If the company intends to change the guaranteed interest rates specified in the form, notification must be submitted to the department prior to the change. The notification must specify the new guaranteed interest rate and the date when the new guaranteed interest rate will be effective for new issues of a specified policy form, as required by §3.1004 of this title (relating to Policy Form Review).

(A) For variable annuities, the actuarial information must provide the information required in this paragraph and the information required by §3.705 of this title (relating to Contract Requirements), to the extent such material is applicable.

(B) For policies or contracts that contain a market-value adjustment, the actuarial memorandum must:

(i) identify the name of the separate account;

(ii) indicate the basis for the market-value adjustment formula and that the formula provides reasonable equity to both the contract holder and the company;

(iii) detail that the reserve liabilities are established in accordance with actuarial procedures that recognize that assets of the separate account are based on market values, the variable nature of the benefits provided, and any mortality guarantees;

(iv) include a table of minimum guaranteed policy values and cash surrender values which:

(I) are based on the longest guaranteed investment period,

(II) reflect both upward and downward market-value adjustments; and

(III) show that the minimum guaranteed values prior to the adjustment are not less than the minimum nonforfeiture values required by law; and

(v) provide a numerical illustration reproducing the values shown in the table for the first, second, and third years of investment, and at the end of the guaranteed investment period.

(3) Group and individual Medicare supplement (including Medicare SELECT) rate filings must be accompanied by supporting actuarial information as required by Subchapter T of this chapter.

(4) Group and individual long-term care:

(A) rate filings must be accompanied by supporting actuarial information as required by Subchapter Y of this chapter; and

(B) annual reports must include the rates, rating schedule, and supporting documentation as required by Insurance Code §1651.053(c).

(5) Individual accident and health premium rate increases which result in any policyholder experiencing an increase in premium rate greater than or equal to 50% in any 12-month period must be accompanied by actuarial information which includes, at a minimum, the items of information specified in subparagraphs (A) - (E) of this paragraph. For the purpose of this paragraph, an increase in premium rate greater than or equal to 50% in any 12-month period means the cumulative increase with respect to such premium considered over a 12-month period.

(A) The form number or numbers to which the submitted rate increase applies.

(B) The planned effective date of the increased rate.

(C) The schedule or schedules of rates to be used.

(D) A concise explanation of the rating process, including assumptions, claims data, methodology, and formulas used in development of gross premium rates.

(E) A statement of actual and projected experience as a basis for the rate adjustments.

(6) Discretionary group filings must be accompanied by supporting actuarial information as required by Insurance Code §1131.064 and §1251.056.

(r) Filing Fee.

(1) The appropriate filing fee for filings for approval (excluding prepaid legal filings) are set forth in subparagraphs (A) - (J) of this paragraph.

(A) For each contract or policy, including Certification Form for Prototype Forms Figure Number 45, its certificate, approved or exempted application, and all approved or exempted riders filed as part of the entire policy or contract, a fee of $100 is required.

(B) For a filing of applications filed separately from the policy or contract to which it will be attached, a fee of $100 is required.

(C) For a filing of riders filed separately from the policy or contract to which it will be attached, a fee of $100 is required.

(D) For a filing of rates filed separately from the policy(ies) or contract(s) to which it is applicable, that require approval by the department as specified in §3.1(9) of this title (relating to Scope), a fee of $100 is required.

(E) For a filing of alternate face pages with constitution and bylaws, articles of incorporation, or trust agreements, a fee of $100 is required.

(F) For a filing of insert pages filed subsequent to the original approval of a policy, a fee of $100 is required.

(G) For filings which normally would be considered exempt, but which, due to certain reasons specified in Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review) are required to be submitted to the department for approval, a fee of $100 is required.

(H) For filing a resubmission of a previously disapproved form, a fee of $50 is required.

(I) For each refiling of a previously withdrawn form, a fee of $50 is required.

(J) For a filing of matrix provisions, due to the ability to create multiple contracts or policies from matrix provisions, a fee of $50 per form with a maximum fee of $500 is required.

(2) The appropriate filing fee for a filing exempt under Subchapter Z of this chapter is set forth in subparagraphs (A) - (H) of this paragraph, as follows:

(A) For each exempt policy or contract filed simultaneously with its certificate, application, and exempt riders which are filed as part of the entire policy or contract, a fee of $50 is required.

(B) For a filing of exempt applications filed separately from the exempt policy or contract to which it will be attached, a fee of $50 is required.

(C) For a filing of exempt riders filed separately from the exempt policy or contract to which it will be attached, a fee of $50 is required.

(D) For a filing of rates filed separately from the exempt policy or contract to which it is applicable, and which is not subject to approval by the department as specified in §3.1(11)(A) of this title, a fee of $50 is required.

(E) For a filing of outlines of coverage filed separately from the exempt policy or contract to which it is applicable, and which is not subject to approval by the department as specified in §3.1(11)(A) of this title, a fee of $50 is required.

(F) For a filing of alternate face pages filed subsequent to the original approval of a policy for use with multiple employer trusteed arrangements as defined in Insurance Code §1131.053 and §1251.053, a fee of $50 is required.

(G) For a filing of exempt insert pages filed separately from the exempt policy or contract to which it is applicable, a fee of $50 is required.

(H) For a filing of exempt matrix provisions to be used with only exempt products, a fee of $50 per form with a maximum fee of $500 is required.

(3) The appropriate filing fees for filings other than those specified in paragraphs (1) and (2) of this subsection are set forth in subparagraphs (A) - (C) of this paragraph, as follows:

(A) For a filing of outlines of coverage filed separately from the policy or contract to which it is applicable, and which is subject to review by the department, a fee of $50 is required.

(B) For a filing of PPO disclosures filed separately from the policy or contract to which it is applicable, and which is subject to review by the department, a fee of $50 is required.

(C) For a filing of Accident and Health or Life rates filed separately from the policy or contract to which it is applicable, and which is subject to review by the department, a fee of $50 is required.

(4) Filings as described in §3.1(11)(B) of this title require no filing fee.

§3.6. Certifications, Attachments, and Additional Information Requirements.

(a) A company must include the certification(s), attachment(s), and additional information referred to in this section as follows:

(1) A filing must include the following certifications, as applicable:

(A) Specific certification. Filings submitted as file and use pursuant to §3.5(a)(2) of this title (relating to Filing Authorities and Categories) must certify that:

(i) the certification is on behalf of the company;

(ii) the company is bound thereby;

(iii) the company has reviewed, and is familiar with, all applicable statutes and regulations of this state and of the United States;

(iv) the company has reviewed the filing; and

(v) to the best of the company's knowledge, information, and belief, the filing complies in all respects with the applicable statutes and regulations of this state.

(B) General certification. Filings submitted other than file and use must certify that:

(i) the certification is on behalf of the company;

(ii) the company is bound thereby;

(iii) the company has reviewed the filing; and

(iv) to the best of the company's knowledge, information, and belief, the filing complies with the applicable statutes and regulations of this state.

(2) A company submitting a filing as file and use must, in addition to providing the certification specified in paragraph (1) of this subsection, complete the appropriate certification on the transmittal checklist certifying that:

(A) no corrections to the form have been requested by the department; and

(B) the form has not been previously disapproved by the department.

(3) A company submitting a form substantially similar to a previously approved form or an exact copy of a previously approved form must provide the certification specified in paragraph (1) of this subsection, and on the transmittal checklist must provide the following information and certification(s):

(A) the form number and approval date of the previously approved form, including the company's name if different from the submitting company;

(B) a summary of the difference(s) between the previously approved form and the new form, including a description of any deleted text, and a clear identification of all changes with new or modified text underlined; and

(C) a certification that no changes have been made to the form other than those identified.

(4) A company submitting a form as a substitution of a previously approved or exempted form must provide the certification specified in paragraph (1) of this subsection, and on the transmittal checklist must provide the following information and certification(s):

(A) the form number and approval or exemption date of the previously approved or exempted form;

(B) a summary of the difference(s) between the previously approved or exempted form and the new form, including a description of any deleted text, and a clear identification of all changes with new or modified text underlined;

(C) a certification that no changes have been made to the form other than those identified; and

(D) a certification that the original version of the form has not been issued or otherwise used in Texas, and will not be issued or used in Texas at any time.

(5) A company submitting a form as a correction to a pending form must provide the certification specified in paragraph (1) of this subsection, and on the transmittal checklist must provide the following information and certification(s):

(A) the form number of the pending form;

(B) the name of the department's form review specialist who reviewed the form;

(C) the date of notification of any form deficiencies;

(D) the tracking number of the pending form as assigned by the department;

(E) a summary of the difference(s) between the previously reviewed form and the corrected form, including a description of any deleted text, and a clear identification of all changes, with new or modified text underlined; and

(F) a certification that no changes have been made to the form other than those identified.

(6) A company submitting a form as a resubmission of a previously disapproved form must provide the certification specified in paragraph (1) of this subsection, and on the transmittal checklist must provide the following information and certification(s):

(A) the form number of the disapproved form;

(B) the name of the department's form review specialist who reviewed the form;

(C) the date of disapproval by the department;

(D) the tracking number of the disapproved form as assigned by the department;

(E) a summary of the difference(s) between the disapproved form and the new form, including a description of any deleted text, and a clear identification of all changes, with new or modified text underlined; and

(F) a certification that no changes have been made to the form other than those identified.

(7) A company submitting a supplemental coverage filing pursuant to §3.3080 of this title (relating to Supplemental Coverage) or Insurance Code §1131.051 or §1131.053 must complete the appropriate certification on the transmittal checklist certifying that the policy will be marketed only as supplemental coverage.

(8) A company submitting a filing as a matrix filing or as an insert page pursuant to §3.4(f) and (g) of this title (relating to General Submission Requirements) must, in addition to providing the certification specified in paragraph (1) of this subsection, complete the appropriate certification on the transmittal checklist certifying that, when issued, the policies, certificates, contracts, riders, or applications created from such forms comply in all respects with the applicable statutes and regulations of this state and of the United States with regard to the final product issued.

(9) A company submitting a filing as exempt pursuant to §3.5(a)(3) of this title (relating to Filing Authorities and Categories) must, in addition to the certification specified in paragraph (1) of this subsection, complete the appropriate certification on the transmittal checklist certifying:

(A) the form filed is not deceptive or misleading;

(B) the form filed does not contain exceptions or conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverages of the policy;

(C) the form filed meets the criteria specified in §3.4004 of this title (relating to Exempt Forms);

(D) the form filed does not contain any new, uncommon, or unusual provisions, conditions, or concepts as provided in §3.4006 of this title (relating to New, Uncommon, and Unusual Forms);

(E) the company submitting the filed form has had a certificate of authority to do such business in Texas for a period not less than two years as required in §3.4007 of this title (relating to Newly Licensed Insurers); and

(F) the use of the form filed will be discontinued in the event of future changes in laws or rules that would prohibit the use of such forms.

(b) A company must include any applicable readability certifications, in accordance with Subchapter G of this chapter (relating to Plain Language Requirements for Health Benefit Policies), §3.3092(c) of this title (relating to Format, Content, and Readability for Outline of Coverage), §3.3102(g) of this title (relating to Language Readability), or any other statutes and regulations of this state.

(c) A company submitting a filing for a group policy or contract must:

(1) on the transmittal checklist, specify the specific group type under which the form is being filed by indicating the appropriate section as set forth in Insurance Code Chapter 1131 and Chapter 1251, or §21.2702(1) and (2) of this title (relating to Definitions) and for Chapter 26 filings, specify the size of the group. Any filing submitted under an ineligible group type will not be accepted for review by the department, and will be returned to the company as incomplete;

(2) submit a separate policy and certificate, each with a unique identifying form number, for each group type that the filing will be issued to; and

(3) submit the following required information for certain group filings.

(A) Filings subject to Insurance Code Chapter 26 of this title (relating to Employer-Related Health Benefit Plan Regulations) must comply with all filing requirements set forth in Chapter 26 of this title.

(B) Filings to be issued to an association must include a copy of the association's constitution, bylaws, and articles of incorporation that demonstrate that the association meets the requirements of Insurance Code §§1131.060, 1251.052, or 21.2702(1) or (2) of this title.

(C) Filings to be issued to an association may be submitted on an "ABC association" basis provided that, if approved, each time the form is issued to a different eligible association, the company submits:

(i) a copy of the eligible association's constitution, bylaws, and articles of incorporation; and

(ii) an alternate face page which identifies the association with either the policy number assigned or a unique form number;

(D) Accident and health filings to be issued to associations participating in a multiple association trusteed arrangement must be accompanied by:

(i) a listing of all the associations participating in the multiple association trusteed arrangement;

(ii) a copy of the trust agreement; and

(iii) a copy of each eligible association's constitution, bylaws, and articles of incorporation.

(E) A company that has received approval for a filing to be issued to associations participating in a multiple association trusteed arrangement must notify the department of any subsequent additions of participating associations upon enrollment and include the documentation required in subparagraph (D) of this paragraph for each association that joins the trust after approval of the initial filing.

(F) Filings to be issued to a multiple employer trusteed group:

(i) must be accompanied by a copy of the trust agreement;

(ii) must include an alternate face page for each related industry group, with a unique form number assigned; and

(iii) may be submitted on an "ABC Trust" basis provided that, if approved, each time the form is issued to a different eligible trust, the company submits:

(I) a copy of the individual trust agreement; and

(II) an alternate face page, identifying the policyholder, the industry, and the policy number assigned to each industry.

(d) The department may request any additional information necessary for a comprehensive review of any form.

§3.7. Form Acceptance and Procedures.

(a) Acceptance or rejection.

(1) A filing received by the department which is in compliance with the requirements of this subchapter and §7.1302 of this title (relating to Billing System) will be accepted and processed according to subsection (b) of this section.

(2) A filing received by the department which fails to comply with this subchapter and §7.1302 of this title will be rejected and returned to the company with a letter or electronic notification indicating the reason(s) for the rejection.

(b) Accepted filings.

(1) Review period for filings subject to approval. Filings subject to approval will be reviewed for compliance with the Insurance Code, this title, or any other applicable law of this state or the United States. Such filings, after review, will be affirmatively approved or disapproved within the applicable statutory deemer period, unless the department initiates a request for correction as set forth in subsection (c) of this section.

(2) Date for exempt filings. Filings submitted pursuant to Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident,

Health, and Annuity Forms and Expedition of Review) are considered exempt as of the date received by the department; however, such filings are subject to audit as specified in §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms).

(3) Date for informational filings. Informational filings are considered filed as of the date received by the department.

(c) Request for correction.

(1) In lieu of issuing a disapproval of a filing, the department may request corrections be made to a form which contains compliance deficiencies provided that at the time of initial notification of any deficiencies, the company either:

(A) requests a 45-day extension of the review period for purposes of bringing the submission into compliance; or

(B) provides a waiver of the company's right to deem the filing approved.

(2) If the company fails to comply with paragraph (1) of this subsection, a disapproval letter or electronic notification will be sent by the department.

(3) The department may notify a company of a request for corrections by telephone, facsimile transmission, or by written or electronic request.

(4) If a company fails to submit corrections to the department within 30 days after notification of any deficiencies and request for corrections, the department will consider the form withdrawn from review by the company. The department will not give any withdrawn form consideration until the company resubmits the form as a new filing.

(5) If the department finds a form violates or does not comply with the insurance or administrative code and requests corrections, the department may request or, after notice and opportunity for hearing, order that the company either replace any

previously used, issued, or delivered form with a corrected form, correct the form by rider, or discontinue using the form.

(d) Disapproval of a form.

(1) The department may disapprove any form if:

(A) the form fails to comply with any applicable statutes or regulations of this state or the United States;

(B) the content of the form is unjust, encourages misrepresentation, or is in any way deceptive; or

(C) the form is a group filing that has been submitted and accepted for review under a group type that is ineligible under the provisions of Insurance Code Chapter 1131 and Chapter 1251 and §21.2702(1) and (2) of this title (relating to Definitions).

(2) When the department disapproves a form pursuant to paragraph (1) of this subsection, the department may request that the company replace any form previously used, issued, or delivered, with a corrected form, or correct the form by rider. The department may also request that the company discontinue using the form if, prior to receiving approval from the department, any form has been used, issued, or delivered.

(e) Withdrawal of approval.

(1) The department may notify any company, by telephone, facsimile transmission, or by written or electronic request, of compliance deficiencies in a previously approved or exempted form. The department may accompany such notice with a request that the company either replace any previously used, issued, or delivered form with a corrected form, correct the form by rider, or discontinue using the form.

(2) The department may, after notice and opportunity for hearing, withdraw previous approval of forms pursuant to Insurance Code §§1701.055(a), 1701.055(d), or 1701.057(a).

(3) When the department withdraws approval of a form pursuant to paragraphs of this subsection and the company has previously used, issued, or delivered the form in this state, the department may direct that the company either replace any previously used, issued, or delivered form with a corrected form, correct the form by rider, or discontinue using the form.

(f) Departmental notice of action. The department will send written or electronic notification, when the processing of the filing has been completed, of any actions taken by the department including, but not limited to, approval, disapproval, withdrawal, or exemption of any filing under this subchapter.

(1) Notices of approval will be in the form of a letter or electronic notification stating the form number, if applicable, and the effective date of the approval.

(2) Notices of disapproval will be in the form of a letter or electronic notification stating the form number, if applicable, the effective date of the disapproval, and the compliance deficiencies.

(3) Notices of acceptance for exemption, substitution, and filing for information will be in the form of a letter or electronic notification stating the form number, if applicable, and the date of acceptance of such filing.

(4) Notice of other actions including, but not limited to, audits, deficiencies, noncompliance, and withdrawals will be in the form of a letter or electronic notification stating the form number and any deficiencies, if applicable.

(5) Notices of disapproval that result from a filing being submitted under an ineligible group type as described in subsection (d)(1)(C) of this section will be in the form of a letter or electronic notification stating the form number, if applicable, the effective date of the decision, and that the disapproval resulted from the filing of an ineligible group type. A comprehensive review of the text of the form will not be completed for forms filed for use with ineligible group types.

(6) Companies must retain the written notification or a copy of the electronic notification as documentation of the department's action on a form.

(7) The department will maintain copies of the filing and the notice of departmental action and such will be the official record.

SUBCHAPTER B. INDIVIDUAL LIFE INSURANCE POLICY FORM CHECKLIST AND AFFIRMATIVE REQUIREMENTS
28 TAC §§3.104, 3.105, 3.107, 3.108, 3.114, 3.115, 3.124, and 3.127

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter B under Insurance Code §§1153.005, 1251.008, 1273.005, 1701.060, and 36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §1251.008 states that the Commissioner may adopt rules necessary to administer Chapter 1251.

Insurance Code §1273.005 specifies that the Commissioner may adopt rules to implement Chapter 1273, Subchapter A.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.104. Incontestable Clause.

(a) The policy must provide that it will be incontestable not later than two years from its date as provided in Insurance Code §1101.006. If a reinstatement is contested for

misrepresentation, then no representation other than one causing the reinstatement may be used to contest the policy. Any contest of the reinstatement may be for a material and fraudulent misrepresentation only and reinstatement may not be contested more than two years after it is effectuated, provided that this provision does not affect the company's right to contest a policy for a representation respecting the initial policy issuance or a different reinstatement during the incontestable period applicable to such issuance or reinstatement. Accidental death benefits and disability benefits need not be subject to such provision.

(b) Any provision which could lengthen the contestable period of a policy beyond two years from its date is prohibited. For example, the policy may not state that it is incontestable after two years "while the policy is continuously in force."

(c) The policy may contain provisions which allow its validity to be contested at any time whatsoever for:

(1) nonpayment of premium; or

(2) violation of the conditions of the policy relating to naval or military services in time of war. Note: War clauses are discussed in §3.118(e) of this title (relating to Conversion Provision).

(d) If the form under review contains no reference to contest after reinstatement, it will also be acceptable.

(e) If more than one person is insured, the policy form must state that it is incontestable with respect to each insured.

§3.105. Statements of the Insured.

(a) The policy must provide that all statements made by the insured will, in the absence of fraud, be deemed representations and not warranties. The policy may provide

that statements made on behalf of the insured will also, in the absence of fraud, be deemed representations and not warranties.

(b) Policy applications sometimes contain agreements which call attention to some, or all, of the elements which must be proved in avoiding the policy for misrepresentation. Such agreements are acceptable, provided:

(1) they do not attempt to burden the insured's representations with the legal consequences of warranties;

(2) they do not attempt to require the insured to prove the nonexistence of grounds upon which the insurer could contest the policy; and

(3) they do not attempt to permit the insurer to avoid liability on grounds less stringent than under Insurance Code §705.004 or other applicable law.

§3.107. Policy Loans.

(a) A policy loan provision is not required in term insurance policies, nor in pure endowments issued or granted as original policies or in exchange for lapsed or surrendered policies.

(b) Loans must be made available at any time while the policy is in force after premiums for three full years have been paid and a cash value is available.

(c) The loan clause must provide for proper assignment of the policy to the company.

(d) The policy must be the sole security for the loan.

(e) Insurance Code Chapter 1110 deals with interest rates. Insurers may comply with Chapter 1110 by refiling reprinted and renumbered policies with a new loan provision or by filing a loan endorsement which may be attached to newly issued policies on and after an effective date specified by the insurer. The maximum rate of interest must be

specified in the policy or loan endorsement. The policy may provide that interest may be made payable in advance to the end of the current policy year.

(f) The loan clause must provide for lending a sum equal to, or at the option of the policy owner, less than, the cash value of the policy and of any dividend additions thereto.

(g) The policy may provide that the company may deduct from such loan value any existing indebtedness on the policy and any unpaid balance of the premium for the current policy year and may collect interest in advance on the loan to the end of the current year.

(h) The policy may provide that loans may be deferred for not more than six months after application therefor is made. The six-month period may commence with the date of receipt of the request by the company, if the policy so provides.

(i) The loan clause must provide that failure to repay any such advance, or to pay interest thereon, will not void the policy until the total indebtedness thereon to the company equals or exceeds the cash value. The policy may not be terminated merely for failure to pay loan interest when due. Since the policy may be voided when the indebtedness equals or exceeds the cash value, this provision may be so worded that benefits cease upon the precise moment that the indebtedness equals such value.

(j) No condition other than as herein provided will be exacted as a prerequisite to any such loan.

§3.108. Automatic Nonforfeiture Benefits.

(a) Nonforfeiture values are governed by Insurance Code Chapter 1105.

(b) Occasionally, the cash value (because of the inclusion of accumulated dividends, coupon benefits, or other guaranteed returns) is more than sufficient to purchase the maximum amount of extended term insurance available under the policy. In such cases, the policy must clearly provide for the equitable disposition of the entire cash value.

(c) Automatic nonforfeiture benefits are not applicable to single premium policies.

§3.114. Dependent Child Riders and Family Term Riders.

(a) The rider must specify the effect on the rider of the death of the insured(s) under the base policy prior to the expiry date(s) of the rider. The following are acceptable:

(1) the rider may terminate, in which case no incontestability provision is required;

(2) the rider may convert to paid-up term insurance;

(3) if paid-up term insurance can be surrendered for its cash value, the rider must contain the "surrender within 30 days" statement required by Insurance Code §1105.007; or

(4) the premium for the rider may be waived to the expiry date(s).

(b) If paid-up term insurance is available on the death of the insured under the base policy, the rider or the policy may not provide an incontestable provision for the rider less favorable than specified in Insurance Code §1101.006 with respect to the coverage for each insured from the date the coverage for that insured becomes effective.

(c) The rider or policy must specify the effect on the rider should the insured(s) under the base policy commit suicide.

§3.115. Requirements for a Package Consisting of a Deferred Life Policy with an Accidental Death Rider Attached.

(a) The application must contain a statement which discloses the deferred nature of the insurance and which reflects the amount of insurance in force during the deferred period. It may not state only the ultimate amount.

(b) The brief description on the face page and filing back, if any, must call attention to the deferred nature of the insurance, and in no way refer to the accidental death benefit.

(c) If a separate premium is charged for the accidental death benefit, the schedule page must reflect the gross premium broken down in such a manner as to reflect the gross premium for the deferred life insurance and the accidental death benefit independently.

(d) The policy schedule page must reflect the reduced death benefit payable each year the reduction in benefits is maintained, as well as the ultimate face amount payable after the full face amount becomes available. This provision may be in the form of actual figures, a percentage of the ultimate face amount, the premiums plus interest, if applicable, or other provision not in violation of Insurance Code Chapter 1701 or other laws.

(e) The death benefit during the period of deferred insurance must be as great as the sum of the gross premiums paid (with or without interest). The death benefit may be based on the gross annual premium even though other modes are available under the policy.

(f) The accidental death benefit must be made a part of the entire contract.

(g) The contract of deferred insurance and accidental death benefit must reflect a different form number from any other contract of deferred insurance the company offers.

§3.124. Provisions Relating to Dividends, Coupon Benefits, or Other Guaranteed Returns.

(a) Any provision by which the insurer undertakes to pay specific amounts will be treated as definite contract benefits and valued in accordance with Insurance Code §841.253.

(b) Any policy which contains a provision promising to pay "dividends" from specified sources must clearly state that the payment of such dividends must be made from profits or expense loading.

(c) Any policy which provides for the payment of dividends, coupon benefits, or other guaranteed returns must specify the disposition which will be made of such accumulations if no option is exercised by the policyholder either on their maturity or in the event of default in premium payments. Acceptable dispositions are that they be:

(1) applied to the purchase of additional insurance;

(2) left to accumulate at interest;

(3) withdrawn in cash; or

(4) applied to the payment of premiums.

§3.127. Certain Prohibited Provisions.

(a) Any policy which contains a title, heading, or other indication of its provisions which is misleading will be disapproved. For example, a title, heading, etc., will be misleading if it contradicts the provisions of the policy. A life insurance policy may not be described or referred to as a "bond," nor may premiums be described or referred to as "deposits."

(b) The policy may not contain the words "Approved by the Texas Department of Insurance," "Approved by TDI," "Approved by the commissioner of insurance," or words of a similar import or nature.

SUBCHAPTER C. APPROVAL, DISAPPROVAL, AND WITHDRAWAL OF APPROVAL OF CERTAIN PARTICIPATING POLICY FORMS
28 TAC §§3.203 - 3.205

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter C under Insurance Code §§541.401, 1701.060, and 36.001.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce reasonable rules to accomplish the purposes of Chapter 541, relating to deceptive, unfair, and prohibited practices.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.203. Instructions to Commissioner.

From and after the effective date hereof, the commissioner will not approve any "certain participating" policy form as defined herein. The commissioner will proceed to withdraw approval, under authority of Insurance Code Chapter 1701, of any such forms which have heretofore been approved. Without limiting the generality of the legal bases upon which disapprovals or withdrawals of approvals heretofore granted will be predicated, the department hereby finds and declares as follows:

(1) such policy forms are by their nature unfair, inequitable, misleading, and deceptive, and encourage misrepresentation; and

(2) such policy forms are particularly subject to misleading sales techniques.

§3.204. Material and Information for the Commissioner to Consider.

When any other type participating policies are being reviewed by the commissioner of insurance for approval or disapproval, the commissioner is authorized

to study and take into consideration not only the titles, terms, and text of such policy itself but also the following additional materials, data, evidence, and information to determine whether such policy complies with the provisions hereof and the requirements of the Insurance Code:

(1) any and all advertisements, estimates, comparisons, illustrations, circulars, statements, notices, brochures, pamphlets, letters, posters, announcements, articles, projections, literature, pictures, reports, books, newspapers, magazines, records, films, or other matter of any nature whatsoever made, issued, circulated, published, disseminated, delivered, used, referred to, or placed before the public in any manner whatsoever relating to or in connection with such certain participating policies of insurance;

(2) any and all oral statements, assertions, or representations, the sales techniques or procedures, and the training, study or learning devices or programs made, used, followed, or employed by the agents, employees or representatives of the insurance company;

(3) any other matters set forth in Insurance Code Chapter 541 or other statute of the Insurance Code;

(4) in the event the commissioner finds that such participating policy and such materials referred to previously do not truthfully, correctly, fairly, honestly, adequately, or properly explain and represent such terms, conditions, promises, and benefits of such policy, the commissioner will disapprove such policy under the provisions of Insurance Code Chapter 1701.

§3.205. Construction of Rules.

This subchapter may not be construed to prohibit the use of any provision authorized by Insurance Code §541.056(c) or other applicable statute.

SUBCHAPTER D. INDETERMINATE PREMIUM REDUCTION POLICIES
28 TAC §§3.301, 3.302, 3.308, 3.310, and 3.311

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter D under Insurance Code §§543.001, 1701.060, and 36.001.

Insurance Code §543.001 provides that the Commissioner may adopt and enforce reasonable rules as provided by Chapter 541, Subchapter I, relating to rulemaking, to accomplish the purposes of §543.001(b)(1), prohibiting misrepresentation, as those purposes relate to life insurance companies.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.301. Purpose and Scope.

(a) This subchapter is promulgated to regulate life insurance policies which have the following characteristics:

(1) the premium for the policy is guaranteed for an initial period of time but subsequent to such initial period, a maximum premium charge is specified in the policy; thereafter, the insurer reserves the right to charge a lesser unspecified amount (this type of policy is hereinafter referred to as "an indeterminate premium reduction policy");

(2) one of the purposes of the policy is to provide insureds with insurance coverage at a lower initial premium than would be obtainable from the insurer if the premiums were required to be unchangeable by the insurer for the life of the policy.

(b) A major purpose of this subchapter is to promote an accurate presentation and description to the insurance-buying public of the indeterminate premium reduction policy. Adequate disclosure is one of the principal objectives of the sections. The sections attempt to ensure that prospective insureds receive a fair, adequate, and accurate impression of the true nature of the indeterminate premium reduction policy. Some of the sections also give notice of certain legal interpretations. The sections are supplementary to and cumulative of other statutes and rules including those promulgated under authority of Insurance Code Chapter 541. This subchapter is applied and interpreted in accordance with the foregoing purposes.

§3.302. Policy Form Submission.

(a) No indeterminate premium reduction policy may be approved for use in Texas unless the insurer files with the Texas Department of Insurance in conjunction with such indeterminate premium reduction policy a statement:

(1) that, to the best of its knowledge and belief, the policy submitted is in compliance with this subchapter;

(2) that advertising and solicitation will be in compliance with this subchapter;

(3) that any premium redetermination will not reflect a distribution of company surplus nor a return of previously collected premiums; and

(4) that any nonguaranteed premium rates used to market the policy are lower than rates which the insurer is willing to guarantee in a fixed premium policy with the same or similar benefits for insureds of essentially the same class of risk.

(b) A nonguaranteed premium means any charge for insurance, including any percentage deviation from a maximum charge, that an insurer or insurance agent

mentions or illustrates as a possible charge for coverage other than the maximum guaranteed premium specified in the policy.

§3.308. Minimum Nonforfeiture Values.

The minimum basis for cash values is stated in Insurance Code Chapter 1105, wherein the adjusted premiums are required to be computed as a "uniform percentage of the respective premiums specified by the policy." Maximum guaranteed premiums in the policy are specified premiums as defined by the code. Cash values, if any, will not be required to be redetermined when premiums are reduced for in-force policies. Minimum nonforfeiture values for indeterminate premium group policies on other than the term plan must be calculated in accordance with this section.

§3.310. Artificial Maximum Premiums Prohibited.

(a) No insurer may incorporate an increment into a maximum premium in an indeterminate premium reduction policy in order to be able to show an increased reduction in later policy years or to reduce cash values if any, as provided in Insurance Code Chapter 1105, or reserves as provided in Insurance Code Chapter 425, Subchapter B.

(b) As a condition precedent to policy form approval, there must accompany each submission of an indeterminate premium reduction policy a certification by a qualified actuary to the following: that the maximum premiums specified in the policy do not incorporate an increment as specified in subsection (a) of this section. An approval of a policy form subsequent to receipt of the foregoing certification may not be construed as a determination by the Texas Department of Insurance that the certification is true and accurate.

§3.311. General Enforcement.

A failure to follow and abide by the representations and disclosure provisions required by this subchapter in marketing the indeterminate premium reduction policy is grounds for a withdrawal of approval of the insurer's previously approved indeterminate premium reduction policy forms and is grounds for disapproval of subsequently filed indeterminate premium reduction policy forms. The provisions of this section are additional to and cumulative of all other enforcement provisions provided by law including Insurance Code Chapter 541.

SUBCHAPTER E. GROUP LIFE, AND/OR GROUP ACCIDENT AND HEALTH INSURANCE POLICIES AND CERTIFICATES
28 TAC §3.408

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter E under Insurance Code §§1204.154, 1701.060, and 36.001.

Insurance Code §1204.154 provides that the Commissioner adopt uniform policy provisions, riders, and endorsements for the policy requirement of Insurance Code §1204.153, relating to payments to the Health and Human Services Commission for certain children.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.408. Mandatory Policy Provisions.

(a) Each group policy of accident and sickness insurance that is delivered, issued for delivery, or renewed in Texas on or after January 1, 1988, including a policy issued by a company subject to Insurance Code Chapter 842, must contain a benefit provision which states, "All benefits paid on behalf of the child or children under the policy must be paid to the Texas Health and Human Services Commission" whenever:

(1) the Texas Health and Human Services Commission is paying benefits under Human Resources Code Chapter 31 or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code; and

(2) the parent who is covered by the group policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support.

(b) The insurer or group nonprofit hospital service company must receive at its home office, written notice affixed to the insurance claim that when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to the Texas Health and Human Services Commission.

(c) With respect to any policy forms approved by the Texas Department of Insurance prior to the effective date of this section, an insurer is authorized to achieve compliance with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the Texas Department of Insurance as being in compliance with this section and the provisions of the Insurance Code.

(d) All policies issued or renewed on and after January 1, 1988, will be considered in compliance with this section if they contain the language prescribed within subsection (a) of this section.

SUBCHAPTER G. PLAIN LANGUAGE REQUIREMENTS FOR HEALTH BENEFIT POLICIES
28 TAC §3.601

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter G under Insurance Code §§1501.010, 1501.260, and 36.001.

Insurance Code §1501.010 requires that the Commissioner adopt rules necessary to implement Chapter 1501 and meet the minimum requirements of federal law, including regulations.

Insurance Code §1501.260 requires that health benefit plan issuers use policies and certificates that are written in plain language. Section 1501.260(e) states that a policy or certificate is written in plain language if it achieves the minimum score established by the Commissioner on the Flesch Reading Ease test or an equivalent test selected by the Commissioner.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.601. Purpose and Scope, Applicability, and Definitions Used in This Subchapter.

(a) Purpose and scope. The sections contained in this subchapter are intended to implement Insurance Code §1501.260 and to establish plain language requirements for health benefit plans or forms that will be approved by the department and issued by health carriers in this state. This subchapter establishes the plain language requirements and minimum score for readability for such health benefit plans or forms, in accordance with Insurance Code §1501.260. This subchapter also establishes procedures that health carriers must follow to demonstrate and assure compliance with the new requirements.

(b) Applicability. This subchapter applies to all health benefit plans, including policies, certificates, evidences of coverage, riders, endorsements, amendments, and/or

applications, approved by the commissioner on or after January 1, 1994, and issued in the State of Texas after such date. This subchapter does not apply to a health benefit plan group master policy or to a health benefit plan group master policy application or to an enrollment form for a health benefit plan group master policy when the enrollment form is used solely to enroll individuals in the plan. This subchapter also does not apply to any health benefit plan forms approved by the commissioner under department rules before January 1, 1994.

(c) Definitions.

(1) Commissioner--The commissioner of insurance of the State of Texas.

(2) Form--Any health benefit plan certificate, policy, evidence of coverage, endorsement, amendment, application, or rider.

(3) Franchise insurance policy--An individual health benefit plan under which a number of individual policies are offered to a selected group. The rates for such a policy may differ from the rate applicable to individually solicited policies of the same type and may differ from the rate applicable to individuals of essentially the same class.

(4) Health benefit plan--A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only insurance coverage;

(B) credit insurance coverage;

(C) disability insurance coverage;

(D) specified disease coverage or other limited benefit policies;

(E) coverage of Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care insurance coverage;

(H) coverage limited to dental care;

(I) coverage limited to care of vision;

(J) coverage provided by a single-service health maintenance organization;

(K) insurance coverage issued as a supplement to liability insurance;

(L) insurance coverage arising out of a workers' compensation system or similar statutory system;

(M) automobile medical payment insurance coverage;

(N) jointly managed trusts authorized under 29 United States Code §141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 United States Code §157;

(O) hospital confinement indemnity coverage; or

(P) reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

(5) Health carrier--Any entity authorized under the Insurance Code to provide health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Insurance Code Chapter 842, a health maintenance organization under Insurance Code Chapter 843, and a stipulated premium company under Insurance Code Chapter 884.

(6) Limited benefit policy--A policy that meets the requirements of "limited benefit policy," as defined in §26.4 of this title (relating to Definitions).

SUBCHAPTER H. VARIABLE ANNUITIES
28 TAC §3.702 and §3.704

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter H under Insurance Code §1152.002 and §36.001.

Insurance Code §1152.002 specifies that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement Chapter 1152, including rules establishing requirements for agent licensing, standard policy provisions, and disclosure.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.702. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Agent--Any person, corporation, partnership, or other legal entity which is licensed as a life insurance agent.

(2) Commissioner--The commissioner of insurance of this state.

(3) Flexible premium contract--Any variable annuity contract other than a scheduled premium variable annuity contract.

(4) General account--All assets of the insurer other than assets in separate accounts established pursuant to Insurance Code Chapter 1152, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable annuities.

(5) Net investment return--The rate of investment return to be credited to the variable annuity contract in accordance with the terms of the contract after deductions for tax charges, if any, and for asset charges either at a rate not in excess of that stated in

the contract, or in the case of a contract issued by a nonprofit corporation under which the contractholder participates fully in the investment, mortality, and expense experience of the account, in an amount not in excess of the actual expense not offset by other deductions. The net investment return to be credited to a contract must be determined at least monthly.

(6) Scheduled premium contract--Any variable contract under which both the timing and amount of premium payments are fixed.

(7) Separate account--A separate account established pursuant to Insurance Code Chapter 1152, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(8) Variable annuity contract--Any individual annuity contract or group annuity contract or certificate issued in connection with a group annuity master contract which provides for benefits which vary according to the investment experience of a separate account established and maintained by the insurer as to such contract, pursuant to Insurance Code Chapter 1152. Annuity benefits may be payable in fixed or variable amounts or both.

§3.704. Separate Accounts.

(a) Establishment of separate account. Any domestic life insurance company issuing variable annuity contracts must establish one or more separate accounts pursuant to Insurance Code Chapter 1152.

(1) If no law or other regulation provides for the custody of separate account assets, and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets must be in writing, and the commissioner has authority to review and disapprove both the terms of any such contract and the proposed custodian prior to the transfer of custody.

(2) In connection with the handling of separate account assets, such insurer may not without prior written approval of the commissioner, employ in any material manner any person who:

(A) within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of 18 United States Code §§1341, 1342, or 1343, as amended; or

(B) within the last 10 years has been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(C) within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state laws involving fraud, deceit, or knowing misrepresentation.

(3) All persons with access to the cash, securities, or other assets allocated to or held by the separate account must be under bond in the amount of not less than $100,000.

(b) Amounts in the separate account. The insurer must maintain in each separate account assets with a value at least equal to the valuation reserves for the variable portion of the variable annuity insurance contracts and other contractual liabilities.

(c) Investments by the separate account. No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts, unless:

(1) 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

(2) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(d) Limitations on ownership.

(1) A separate account may not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investments of such account in such security valued as required by this subchapter, would exceed 10% of the value of the assets of the separate account. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or the contractholders in this state, the commissioner may in writing waive this limitation.

(2) No separate account may purchase or otherwise acquire the voting securities of any issuer if, as a result of such acquisition, the insurer and its separate accounts in the aggregate will own more than 10% of the total issued and outstanding voting securities of such issuer. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or the contractholders in this state, the commissioner may in writing waive this limitation.

(3) The percentage limitation specified in paragraph (1) of this subsection may not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to 15 United States Code §§80b-1 to 80b-21, as amended or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially

with the provisions of subsection (c) of this section and other applicable portions of this regulation.

(e) Valuation of separate account assets. Investments of the separate account must be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

(f) Separate account investment policy. The investment policy of a separate account operated by a domestic insurer filed under §3.703(2)(c) of this title (relating to Qualifications of Insurer To Issue Variable Annuities) may not be changed without first filing such change with the commissioner.

(1) Any change filed pursuant to this subsection will be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of disapproval of the proposed change. At any time, the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to this subsection.

(2) The commissioner may disapprove the change if the commissioner determines that the change would be detrimental to the interest of the contractholders participating in such separate account.

(g) Charges against separate accounts. The insurer must disclose in writing, prior to or contemporaneously with delivery of the contract, all charges that may be made against the separate account, including, but not limited to, the following:

(1) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(2) actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(3) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(4) a charge, at a rate specified in the policy, for any mortality and expense guarantees;

(5) any amounts in excess of those required to be held in the separate account; and

(6) charges for incidental insurance benefits.

(h) Standards of conduct. Every insurer seeking approval to enter into the variable annuity business in this state must adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct are binding on the insurer and those to whom it refers. A code of ethics meeting the requirements of 15 United States Code §80a-17, as amended, and applicable rules and regulations thereunder will satisfy the provisions of this subsection.

(i) Conflicts of interest. Rules adopted under any provisions of the Insurance Code or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interests also apply to members of any separate account's committee or other similar body.

(j) Investment advisory services to a separate account. An insurer may not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable annuity contracts unless:

(1) the person providing such advice is registered as an investment advisor under 15 United States Code §§80b-1 to 80b-21, as amended; or

(2) the person providing such advice is an investment manager under 29 United States Code §1001, et seq., as amended, with respect to the assets of each employee benefit plan allocated to the separate account; or

(3) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(A) the name and form of organization, and its principal place of business;

(B) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, the name and address of such individual;

(C) a written standard of conduct complying in substance with the requirements of subsection (h) of this section which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

(D) a statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(i) has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer, or director of an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of 18 United States Code §§1341, 1342, or 1343;

(ii) has been permanently or temporarily enjoined by an order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(iii) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under such laws; or

(iv) has been censored, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(4) such investment advisory contract must be in writing and provide that it is subject to review and termination by the commissioner at any time, and that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment advisor. The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if the commissioner deems continued operation thereunder to be hazardous to the public or the insurer's contractholders.

SUBCHAPTER I. VARIABLE LIFE INSURANCE
28 TAC §§3.802 - 3.806 and 3.811

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter I under Insurance Code §1152.002 and §36.001.

Insurance Code §1152.002 specifies that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement Chapter 1152, including rules establishing requirements for agent licensing, standard policy provisions, and disclosure.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.802. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Affiliate of an insurer--Any person, directly or indirectly, controlling, controlled by, or under common control with such insurer; any person who regularly furnishes investment advice to such insurer with respect to its separate accounts for which a specific fee or commission is charged; or any director, officer, partner, or employee of such insurer, controlling or controlled person, or person providing investment advice or any member of the immediate family of such person.

(2) Agent--Any person, corporation, partnership, or other legal entity which is licensed by this state as a life insurance agent.

(3) Assumed investment rate--The rate of investment return which would be required to be credited to a variable life contract, after deduction of charges for taxes, investment expenses, and mortality and expense guarantees to maintain the variable death benefit equal at all times to the amount of death benefit, other than incidental insurance benefits, which would be payable under the plan of insurance if the death benefit did not vary according to the investment experience of the separate account.

(4) Benefit base--The amount to which the net investment return is applied.

(5) Cash surrender value--The net cash surrender value plus any amounts outstanding as contract loans.

(6) Commissioner--The commissioner of insurance of this state.

(7) Contract cost factors--Those amounts which affect the price per thousand of life insurance coverage or other benefits. They include interest, mortality, expense charges, and fees, including any surrender charges, but not persistency assumptions.

(8) Contract processing day--The day on which charges authorized in the contract are deducted from the contract value.

(9) Contract value--The amount to which interest is credited, and against which separately identified mortality charges, expense charges, fees, and other charges are debited.

(10) Control (including the terms "controlling," "controlled by," and "under common control with")--The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing more than 10% of the voting securities of any other person. This presumption may be rebutted by a showing made to the satisfaction of the commissioner that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(11) Flexible premium contract--Any variable life contract other than a scheduled premium variable life contract as defined in the definition of scheduled premium variable life contract.

(12) General account--All assets of the insurer other than assets in separate accounts established pursuant to Insurance Code Chapter 1152, or pursuant to the corresponding sections of the insurance laws of the state of domicile of a foreign or alien insurer, whether or not for variable life insurance.

(13) Incidental insurance benefit--All insurance benefits in a variable life contract, other than the variable death benefit and the minimum death benefit, including, but not limited to, accidental death and dismemberment benefits, disability benefits, guaranteed insurability options, family income, or term riders.

(14) Minimum death benefit--The amount of the guaranteed death benefit, other than incidental insurance benefits, payable under a variable life contract regardless of the investment performance of the separate account.

(15) Net cash surrender value--The maximum amount payable to the contract owner upon surrender.

(16) Net investment return--The rate of investment return in a separate account to be applied to the benefit base.

(17) Person--An individual, corporation, partnership, association, trust, or fund.

(18) Scheduled premium contract--Any variable life contract under which both the amount and timing of premium payments are fixed by the insurer.

(19) Separate account--A separate account established pursuant to Insurance Code Chapter 1152, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(20) Structural changes--Those changes which are separate from the automatic workings of the contract. Such changes usually would be initiated by the contract owner and include changes in the guaranteed benefits, changes in latest maturity date, or changes in allowable premium payment period.

(21) Variable death benefit--The amount of the death benefit, other than incidental benefits payable under a variable life contract dependent on the investment performance of the separate account, which the insurer would have to pay in the absence of any minimum death benefit.

(22) Variable life contract--Any individual variable life insurance contract which provides for life insurance the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such contract, pursuant to Insurance Code Chapter 1152, or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

§3.803. Qualifications of Insurer to Issue Variable Life Insurance.

The following requirements are applicable to all insurers either seeking authority to issue variable life insurance in this state or having the authority to issue variable life insurance in this state.

(1) Licensing and approval to do business in this state. An insurer may not deliver or issue for delivery in this state any variable life insurance contracts unless:

(A) the insurer is licensed or organized to do a life insurance business in this state; and

(B) after having complied with the provisions of Insurance Code Chapter 1152, concerning notice and hearing, the commissioner has authorized, either as part of the insurer's original certificate of authority or by charter amendment, the insurer to issue, deliver, and use variable life contracts, and only after the commissioner has considered among other things the following:

(i) whether the plan of operation for the issuance of variable life contracts is sound;

(ii) whether the general character, reputation, and experience of the management and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer are such as to reasonably assure competent operation of the variable life business of the insurer in this state; and

(iii) whether the present and foreseeable future financial condition of the insurer and its method of operation in connection with the issuance of such contracts is not likely to render its operation hazardous to the public or its contractholders in this state. The commissioner will consider, among other things:

(I) the history of operation and financial condition of the insurer;

(II) the qualifications, fitness, character, responsibility, reputation, and experience of the officers and directors and other management of the insurer and those persons or firms proposed to supply consulting, investment, administrative, or custodial services to the insurer;

(III) the applicable law and regulations under which the insurer is authorized in its state of domicile to issue variable life contracts. The state of entry of an alien insurer will be deemed its state of domicile for this purpose; and

(IV) if the insurer is a subsidiary of, or is affiliated by common management or ownership with, another company, its relationship to such other company and the degree to which the requesting insurer, as well as the other company, meets these standards.

(2) Filing for approval to do business in this state. Before any insurer may deliver or issue for delivery any variable life contract in this state, it must file with the Texas Department of Insurance the following information, and any other information specifically requested, for the consideration of the commissioner, on making the determination required by paragraph (1)(B) of this section:

(A) copies of and a general description of the variable life contracts it intends to issue;

(B) a general description of the methods of operation of the variable life insurance business of the insurer, including methods of distribution of contracts and the names of those persons or firms proposed to supply consulting, investment, administrative, custodial, or distributive services to the insurer;

(C) with respect to any separate account maintained by an insurer for any variable life contract, a statement of the investment policy the insurer intends to follow for the investment of the assets held in such separate account, and a statement of procedures for changing such investment policy. The statement of investment policy must include a description of the investment objectives intended for the separate account;

(D) a description of any investment advisory services contemplated as required by §3.806 of this title (relating to Separate Accounts);

(E) a copy of the statutes and regulations of the state of domicile of a foreign or alien insurer under which it is authorized to issue variable life contracts;

(F) biographical data not previously filed with the commissioner with respect to officers and directors of the insurer on the appropriate biographical form used in Texas;

(G) a statement of the insurer's actuary describing the mortality and expense risks which the insurer will bear under the contract; and

(H) the provisions of subparagraphs (A) - (G) of this paragraph will be deemed to have been satisfied to the extent that the information required by the commissioner is provided in form identical to the insurer's registration statement filed under 15 United States Code §77a, et seq.

(3) Standards of suitability. Every insurer seeking approval to enter into the variable life insurance business in this state must establish and maintain a written

statement specifying the standards of suitability to be used by the insurer. Such standards of suitability must specify that no recommendation will be made to an applicant to purchase a variable life contract and that no variable life contract will be issued in the absence of reasonable grounds to believe that the purchase of such contract is not unsuitable for such applicant on the basis of information furnished after reasonable inquiry of such applicant concerning the applicant's insurance and investment objectives, financial situation and needs, and any other information known to the insurer or the agent making the recommendation.

(4) Use of sales material. An insurer authorized to transact variable life insurance business in this state may not use any sales material, advertising material, or descriptive literature or other materials of any kind in connection with its variable life insurance business in this state unless it complies with §§21.101 - 21.122 of this title (relating to Insurance Advertising, Certain Trade Practices, and Solicitation). An insurer issuing flexible premium variable life contracts must provide, to all prospective purchasers, an illustration of cash surrender values prior to or at the time of delivery of the contract. Any illustration of cash surrender values delivered to an applicant or prospective applicant pursuant to this subsection must:

(A) include a hypothetical gross investment return of 0.0%, and when other hypothetical gross investment returns are included, the current gross investment return must, to the extent permitted by federal law, be included;

(B) give equal prominence to both guaranteed and non-guaranteed aspects of the contract if guarantees are included in the contract;

(C) prominently display, by way of written statement, the hypothetical nature of the illustration as it relates to investment returns;

(D) prominently state that a contract may terminate due to insufficient premiums and/or poor investment performance; and

(E) prominently show, by way of written statement, that excessive loans or withdrawals may cause the contract to lapse due to insufficient cash surrender value and, at the option of the insurer, prominently display the effects of loans or withdrawals on contract values.

(5) Requirements applicable to contractual services. Any material contract between an insurer and suppliers of consulting, investment, administrative, sales, marketing, custodial, or other services with respect to variable life insurance operations must be in writing and provide that the supplier of such services furnish the commissioner with any information or reports in connection with such services which the commissioner may request in order to ascertain whether the variable life insurance operations of the insurer are being conducted in a manner consistent with these regulations, and any other applicable law or regulations.

(6) Reports to the commissioner. Any insurer authorized to transact the business of variable life insurance in this state must submit to the commissioner, in addition to any other materials which may be required by this subchapter or any other applicable laws or rules:

(A) an annual statement of the business of its separate account or accounts in such forms as may be prescribed by the National Association of Insurance Commissioners;

(B) prior to use in this state, any information furnished to applicants as provided for in §3.807 of this title (relating to Information Furnished to Applicants);

(C) prior to use in this state, the form of any of the reports to contractholders as provided for in §3.809 of this title (relating to Reports to Contractholders); and

(D) such additional information concerning its variable life insurance operations or its separate accounts as the commissioner deems necessary.

(7) Treatment of material reported under paragraph (6) of this section. Receipt of the material specified in paragraph (6) of this section does not imply approval or acceptance of the material. The commissioner will require the redistribution of any previously distributed material which is found to be false, misleading, deceptive, or inaccurate in any material respect.

(8) Authority of the commissioner to disapprove. Any material required to be filed with the commissioner, or approved by the commissioner, will be subject to disapproval if at any time it is found by the commissioner not to comply with the standards established by these rules.

§3.804. Insurance Contract and Filing Requirements.

The commissioner will not approve any variable life insurance form filed pursuant to these rules unless it conforms to the requirement of applicable law.

(1) Filing of variable life contracts. All variable life contracts, and all riders, endorsements, applications, and other documents which are to be attached to and made a part of the contract and which relate to the variable nature of the contract, must be filed with the commissioner and approved or exempted, as applicable, by the commissioner prior to delivery or issuance for delivery in this state.

(A) Each variable life contract, rider, endorsement, and application must be filed in accordance with Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings. A flexible premium variable life contract submission must be accompanied by the following:

(i) a mathematical demonstration comparing the specimen contract's cash surrender values, assuming the contract's assumed investment rate, if any, or in the absence of an assumed investment rate, on a rate not to exceed the maximum interest rate allowed by Insurance Code Chapter 1105, to the minimum cash surrender

value described in paragraph (2)(F) of this section. The specimen contract should be for the minimum initial face amount permitted to be issued to a male age 35. The demonstration should not assume changes in face amount which are optional to the contractholder. The maturity date and the premium paying period should be the maximum permitted by the contract. The premium for each year should be the greater of the minimum premium permitted for that year or the premium that will allow the contract to mature at the maturity date assuming guaranteed charges and the assumed investment rate, if any, or, in the absence of an assumed investment rate, a rate not to exceed the maximum interest rate permitted by Insurance Code Chapter 1105;

(ii) an actuarial description which sets forth maximum expense charges, loads, and surrender charges, applicable to the contract at issue and upon a change in basic coverage for all ages, bands, and classes of risk, will be provided in conjunction with the contract.

(B) The commissioner may approve variable life contracts and related forms with provisions the commissioner deems to be not less favorable to the contractholder and the beneficiary than those required by these rules.

(2) Mandatory contract benefit and design requirements. Variable life contracts delivered or issued for delivery in this state must comply with the following minimum requirements.

(A) Mortality and expense risks must be borne by the insurer. The expense charges must be subject to the maximums stated in the contract. The charge for mortality must be stated in the contract and may not exceed a mortality rate for the attained age of the insured in a table specified for the calculation of cash surrender values in Insurance Code Chapter 1105. Provided, for insurance issued on a substandard basis, the charge for mortality may be the mortality rate for the attained age of the insured in

such other tables as may be specified by the company and approved by the Texas Department of Insurance.

(B) For scheduled premium contracts, a minimum death benefit must be provided in an amount at least equal to the initial face amount of the contract so long as premiums are duly paid (subject to paragraph (4) of this section).

(C) The contract must reflect the investment experience of one or more separate accounts established and maintained by the insurer. The insurer must demonstrate that the reflection of investment experience in the variable life contract is actuarially sound.

(D) Each variable life contract must be credited with the full amount of the net investment return applied to the benefit base.

(E) Any changes in variable death benefits of each variable life contract must be determined at least annually.

(F) The cash surrender value of each variable life contract must be determined at least monthly. The method of computation of cash surrender values and other nonforfeiture benefits, as described in the contract and in a statement filed with the commissioner in this state in which the contract is delivered, or issued for delivery, must be in accordance with recognized actuarial procedures that recognize the variable nature of the contract. The method of computation must be such that if the net investment return credited to the contract at all times from the date of issue should be equal to the assumed investment rate with premiums and benefits determined accordingly under the terms of the contract, then the resulting cash surrender values and other nonforfeiture benefits must be at least equal to the minimum values required by Insurance Code Chapter 1105, for a general account contract with such premiums and benefits. The assumed investment rate may not exceed the maximum interest rate permitted under Insurance Code Chapter 1105. If the contract does not contain an assumed investment rate, this demonstration

must be based on a rate not to exceed the maximum interest rate permitted under Insurance Code Chapter 1105. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include for example, but are not limited to, a guarantee that the amount payable at death or maturity is at least equal to the amount that otherwise would have been payable if the net investment return credited to the contract at all times from the date of issue had been equal to the assumed investment rate.

(3) Mandatory contract provisions. Every variable life contract filed for approval in this state must contain at least the following.

(A) The cover page or pages corresponding to the cover page of each contract must contain:

(i) a prominent statement in either contrasting color or in boldface type that the amount or duration of death benefit may be variable or fixed under specified conditions;

(ii) a prominent statement in either contrasting color or in boldface type that cash surrender values may increase or decrease in accordance with the experience of the separate account, subject to any specified minimum guarantees;

(iii) a statement describing any minimum death benefit required pursuant to paragraph (2)(B) of this section;

(iv) the method, or a reference to the contract provision which describes the method, for determining the amount of insurance payable at death;

(v) a captioned provision that the contractholder may return the variable life contract within 10 days of receipt of the contract by the contractholder, and receive a refund equal to the premiums paid;

(vi) such other items as are currently required for fixed benefit life contracts and which are not inconsistent with this subchapter.

(B) A grace period in accordance with this subparagraph.

(i) For scheduled premium contracts, a provision for a grace period of not less than 31 days from the premium due date which must provide that when the premium is paid within the grace period, cash surrender values will be the same, except for the deduction of any overdue premium, as though the premium were paid on or before the due date.

(ii) For flexible premium contracts, a provision for a grace period beginning on the contract processing day when the total charges authorized by the contract that are necessary to keep the contract in force until the next contract processing day exceed the amounts available under the contract to pay such charges in accordance with the terms of the contract. Such grace period must end on a date not less than the later of the date 61 days after the contract processing day when the grace period begins, or the date which is 31 days after the mailing date of the report to contractholders required by §3.809(3) of this title (relating to Reports to Contractholders). The death benefit payable during the grace period will equal the death benefit in effect immediately prior to such period less any overdue charges. If the contract processing days occur monthly, the insurer may require payment of an amount equal to the greater of:

(I) not more than three times the charges which were due on the contract processing day on which the amounts available under the contract were insufficient to pay all charges authorized by the contract that are necessary to keep such contract in force until the next contract processing day; or

(II) the amount necessary to keep such contract in force for a period of three calendar months from the contract processing day on which the amounts available under the contract were insufficient to pay all charges authorized by the contract.

(C) For scheduled premium contracts, a provision that the contract will be reinstated at any time within two years from the date of default upon the written application of the insured and evidence of insurability, including good health, satisfactory to the insurer, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the payment of any outstanding indebtedness arising subsequent to the end of the grace period following the date of default together with accrued interest thereon to the date of reinstatement and payment of an amount not exceeding the greater of:

(i) all overdue premiums at an interest rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract, and any indebtedness in effect at the end of the grace period following the date of default with interest at a rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract; or

(ii) 110% of the increase in cash surrender value resulting from reinstatement plus all overdue premiums for incidental insurance benefits with interest at a rate not exceeding the contract loan interest rate in effect for the period during and after the lapse of the contract.

(D) A full description of the benefit base and of the method of calculation and application of any factors used to adjust variable benefits under the contract.

(E) A provision designating the separate account to be used and stating that:

(i) the assets of such separate account must be available to cover the liabilities of the general account of the insurer only to the extent that the assets of the separate account exceed the liabilities of the separate account arising under the variable life contracts supported by the separate account; and

(ii) the assets of such separate account must be valued at least as often as any contract benefits vary but at least monthly.

(F) A provision specifying what documents constitute the entire insurance contract.

(G) A designation of the officers who are empowered to make an agreement or representation on behalf of the insurer and an indication that statements by the insured, or on his or her behalf, are considered as representations and not warranties.

(H) An identification of the owner of the insurance contract.

(I) A provision setting forth conditions or requirements as to the designation, or change of designation, of a beneficiary and a provision for disbursement of benefits in the absence of a beneficiary designation.

(J) A statement of any conditions or requirements concerning the assignment of the contract.

(K) A description of any adjustments in benefits under the contract to be made in the event of misstatement of age or sex of the insured.

(L) A provision that the contract will be incontestable by the insurer after it has been in force for two years during the lifetime of the insured, provided, however, that any increase in the amount of the contract's death benefits subsequent to the contract issue date, which increase occurred upon a new application or request of the owner and was subject to satisfactory proof of the insured's insurability, will be incontestable after any such increase has been in force, during the lifetime of the insured, for two years from the date of issue of such increase.

(M) A provision stating that the investment policy of the separate account may not be changed without the approval of the insurance commissioner of the

state of domicile of the insurer, and that the approval process is on file with the commissioner of this state.

(N) A provision that the payment of variable death benefits in excess of any minimum death benefits, cash surrender values, contracts loans, or partial withdrawals (except when used to pay the premiums) or partial surrenders may be deferred:

(i) for up to two months for death benefit payments or six months for all other payments from the date of request therefor, if such payments are based on contract values which do not depend on the investment performances of the separate accounts; or

(ii) for any period during which the New York Stock Exchange is closed for trading (except for normal holiday closing) or when the Securities and Exchange Commission has determined that a state of emergency exists which may make such payment impractical.

(O) If settlement options are provided, at least one such option must be provided on a fixed basis only.

(P) A detailed and complete definition for the basis for computing the contract value and the cash surrender value of the contract. For flexible premium variable life contracts, the definition must include the following:

(i) the guaranteed maximum expense charges and loads;

(ii) any limitation on the crediting of additional interest. Interest credits may not remain conditional for a period longer than 12 months;

(iii) any assumed investment rate or rates;

(iv) the guaranteed maximum mortality charges;

(v) any other guaranteed charges;

(vi) any surrender or partial withdrawal charges.

(Q) Premiums or charges for incidental insurance benefits must be stated separately.

(R) Any other contract provisions required by this subchapter.

(S) Such other items as are currently required for fixed benefit life insurance contracts and are not inconsistent with this subchapter.

(T) A provision for nonforfeiture insurance benefits. The insurer may establish either a reasonable minimum cash surrender value amount, or a reasonable death benefit which may be purchased under any nonforfeiture option, below which any nonforfeiture option will not be available.

(U) If a flexible premium contract does not provide for a guarantee of death benefit coverage, but does provide for a "maturity date," "end date," or similar date, then the contract must also contain a statement, in close proximity to that date, that it is possible that the coverage may not continue to the maturity date even if scheduled premiums are paid in a timely manner.

(4) Contract loan provision. Every variable life contract, other than term insurance contracts and pure endowment contracts, delivered or issued for delivery in this state must contain provisions which are not less favorable to the contractholders than the following.

(A) A provision for contract loans after the contract has been in force for one full year which provides the following:

(i) at least 75% of the contract's cash surrender value may be borrowed;

(ii) the amount borrowed must bear interest at a rate not to exceed that permitted by Insurance Code Chapter 1110;

(iii) any indebtedness must be deducted from the proceeds payable on death;

(iv) any indebtedness must be deducted from the cash surrender value upon surrender or in determining any nonforfeiture benefit.

(B) For scheduled premium contracts, whenever the indebtedness exceeds the cash surrender value, the insurer must give notice of any intent to cancel the contract if the excess indebtedness is not repaid within 31 days after the date of mailing of such notice. For flexible premium contracts, whenever the total charges authorized by the contract that are necessary to keep the contract in force until the next following contract processing day exceed the amounts available under the contract to pay such charges, a report must be sent to the contractholder containing the information specified by §3.809(3) of this title (relating to Reports to Contractholders).

(C) The contract may provide that if, at any time, so long as premiums are duly paid, the variable death benefit is less than it would have been if no loan or withdrawal had ever been made, the contractholder may increase such variable death benefit up to what it would have been if there had been no loan or withdrawal by paying an amount not exceeding 110% of the corresponding increase in cash surrender values and by furnishing such evidence of insurability as the insurer may require.

(D) The contract may specify a reasonable minimum amount which may be borrowed at any time, but such minimum may not apply to any automatic premium loan provision.

(E) No contract loan provision is required if the contract is under extended insurance nonforfeiture option.

(F) The contract loan provisions must be constructed so that variable life insurance contractholders who have not exercised such provisions are not disadvantaged by the exercise thereof.

(G) Amounts paid to the contractholders upon the exercise of any contract loan provision must be withdrawn from the separate account and must be

returned to the separate account upon repayment except that a stock insurer may provide the amounts for contract loans from the general account.

(5) Other contract provisions. The following provisions may in substance be included in a variable life contract or related form delivered or issued for delivery in this state:

(A) an exclusion for suicide within two years of the issue date of the contract, provided, however, that to the extent of the increased death benefits only, the contract may provide an exclusion for suicide within two years of any increase in death benefits which result from an application or request of the owner subsequent to the contract issue date;

(B) incidental insurance benefits may be offered on a fixed or variable basis;

(C) contracts issued on a participating basis must offer to pay dividend amounts in cash. In addition, such contracts may offer the following dividend options:

(i) the amount of the dividend may be credited against premium payments;

(ii) the amount of the dividend may be applied to provide amounts of additional fixed or variable benefit life insurance;

(iii) the amount of the dividend may be deposited in the general account at a specified minimum rate of interest;

(iv) the amount of the dividend may be applied to provide paid-up amounts of fixed benefit one-year term insurance;

(v) the amount of the dividend may be deposited as a variable deposit in the separate account or separate accounts;

(D) a provision allowing the contractholder to elect in writing in the application for the contract or thereafter an automatic premium loan on a basis not less favorable than that required of contract loans under paragraph (4) of this section, except that a restriction that no more than two consecutive premiums can be paid under this provision may be imposed;

(E) a provision allowing the contractholder to make partial withdrawals; and/or

(F) any other contract provision approved by the commissioner.

§3.805. Reserve Liabilities for Variable Life Insurance.

(a) Reserve liabilities for variable life insurance contracts must be established under Insurance Code Chapter 425, Subchapter B, in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(b) For scheduled premiums contracts, reserve liabilities for the guaranteed minimum death benefit must be the reserve needed to provide for the contingency of death occurring when the guaranteed minimum death benefit exceeds the death benefit that would be paid in the absence of the guarantee, and be maintained in the general account of the insurer and must not be less than the greater of the following minimum reserve:

(1) the aggregate total of the term costs, if any, covering a period of one full year from the valuation date, of the guarantee on each variable life contract, assuming an immediate one-third depreciation in the current value of the assets in the separate account followed by a net investment return equal to the assumed investment rate; or

(2) the aggregate total of the "attained age level" reserves on each variable life insurance contract. The "attained age level" reserve on each variable life insurance contract must not be less than zero and must equal the "residue," as described in

subparagraph (A) of this paragraph, of the prior year's "attained age level" reserve in the contract, with any such "residue," increased or decreased by a payment computed on an attained-age basis as described in subparagraph (B) of this paragraph.

(A) The "residue" of the prior year's "attained age level" reserve on each variable life insurance contract may not be less than zero and must be determined by adding interest at the valuation interest rate to such prior year's reserve, deducting the tabular claims based on the "excess," if any, of the guaranteed minimum death benefit over the death benefit that would be payable in the absence of such guarantee, and dividing the net result by the tabular probability of survival. The "excess" referred to in the preceding sentence must be based in the actual level of death benefits that would have been in effect during the preceding year in the absence of the guarantee, taking appropriate account of the reserve assumptions regarding the distribution of death claim payments over the year.

(B) The payment referred to in this paragraph must be computed so that the present value of a level of that amount each year over the future premium paying period of the contract is equal to (i) minus (iii), where:

(i) is the present value of the future guaranteed minimum death benefits;

(ii) is the present value of the future death benefits that would be payable in the absence of such guarantee; and

(iii) is any "residue," as described in subparagraph (A) of this paragraph, of the prior year's "attained age level" reserve on such variable life insurance contract. If the contract is paid up, the payment must equal (i) minus (ii) minus (iii). The amounts of the future death benefits referred to in clause (ii) of this paragraph must be computed assuming a net investment return of the separate account which may differ

from the assumed investment rate and/or the valuation interest but in no event may exceed the maximum interest rate permitted for the valuation of life contracts.

(3) The valuation interest rate and mortality table used in computing the two minimum reserves described in paragraph (2)(A) and (B) of this subsection must conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the insurer may employ suitable approximations and estimates, including, but not limited to, groupings and averages.

(c) For flexible premium contracts, reserve liabilities for any guaranteed minimum death benefit must be maintained in the general account of the insurer and may not be less than the aggregate total of the term costs, if any, covering the period provided for in the guarantee not otherwise provided for by the reserves held in the separate account assuming an immediate one-third depreciation in the current value of the assets of the separate account followed by a net investment return equal to the valuation interest rate. The valuation interest rate and mortality table used in computing this additional reserve, if any, must conform to permissible standards for the valuation of life insurance contracts. In determining such minimum reserve, the insurer may employ suitable approximations and estimates, including, but not limited to, groupings and averages.

(d) Reserve liabilities for all fixed incidental insurance benefits and any guarantees associated with variable incidental insurance benefits must be maintained in the general account, and reserve liabilities for all variable aspects of the variable incidental insurance benefits must be maintained in a separate account, in amounts determined in accordance with the actuarial procedures appropriate to such benefit.

§3.806. Separate Accounts.

The following requirements apply to the establishment and administration of variable life insurance separate accounts by any domestic insurer.

(1) Establishment of separate accounts. Any domestic life insurance company issuing variable life contracts must establish one or more separate accounts pursuant to Insurance Code Chapter 1152.

(A) If no law or other regulation provides for the custody of separate account assets and if such insurer is not the custodian of such separate account assets, all contracts for custody of such assets must be in writing and the commissioner has authority to review and approve of both the terms of any such contract and the proposed custodian prior to the transfer of custody.

(B) In connection with the handling of separate account assets, such insurer may not without prior written approval of the commissioner, employ in any material manner any person who:

(i) within the last 10 years has been convicted of any felony or a misdemeanor arising out of such person's conduct involving embezzlement, fraudulent conversion, or misappropriation of funds or securities or involving violation of 18 United States Code §§1341, 1342, or 1343, as amended; or

(ii) within the last 10 years had been found by any state regulatory authority to have violated or has acknowledged violation of any provision of any state insurance law involving fraud, deceit, or knowing misrepresentation; or

(iii) within the last 10 years has been found by federal or state regulatory authorities to have violated or has acknowledged violation of any provision of federal or state laws involving fraud, deceit, or knowing misrepresentation.

(C) All persons with access to the cash, securities, or other assets allocated to or held by the separate account must be under bond in the amount of not less than $100,000.

(2) Amounts in the separate account. The insurer must maintain in each separate account assets with a value at least equal to the greater of the valuation reserves

for the variable portion of the variable life insurance contracts or the benefit base for such contracts.

(3) Investments by the separate account.

(A) No sale, exchange, or other transfer of assets may be made by an insurer or any of its affiliates between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(i) 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

(ii) such transfer, whether into or from a separate account, is made by a transfer of cash; but other assets may be transferred if approved by the commissioner in advance.

(B) The separate account must have sufficient net investment income and readily marketable assets to meet anticipated withdrawals under contracts funded by the account.

(4) Limitations on ownership.

(A) A separate account may not purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal and interest by the United States, if immediately after such purchase or acquisition the value of such investment, together with prior investment of such account in such security valued as required by these rules, would exceed 10% of the value of the assets of the separate account. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or contractholders in this state, the commissioner may in writing waive this limitation.

(B) No separate account may purchase or otherwise acquire the voting securities of any issuer if, as a result of such acquisition, the insurer and its separate accounts in the aggregate will own more than 10% of the total issued and outstanding voting securities of such issuer. Upon appropriate documentation by the company, which evidences that a waiver of this limitation will not render the operation of the separate account hazardous to the public or the contractholders in this state, the commissioner may in writing waive this limitation.

(C) The percentage limitations specified in subparagraph (A) of this paragraph may not be construed to preclude the investment of the assets of separate accounts in shares of investment companies registered pursuant to 15 United States Code §§80b-1 - 80b-21, as amended, or other pools of investment assets if the investments and investment policies of such investment companies or asset pools comply substantially with the provisions of paragraph (3) of this section and other applicable portions of this regulation.

(5) Valuation of separate account assets. Investments of the separate account must be valued at their market value on the date of valuation, or at amortized cost if it approximates market value.

(6) Separate account investment policy. The investment policy of a separate account operated by a domestic insurer filed under §3.803(2)(C) of this title (relating to Qualification of Insurer to Issue Variable Life Insurance) may not be changed without first filing such change with the commissioner.

(A) Any change filed pursuant to this paragraph will be effective 60 days after the date it was filed with the commissioner, unless the commissioner notifies the insurer before the end of such 60-day period of the commissioner's disapproval of the proposed change. At any time, the commissioner may, after notice and public hearing, disapprove any change that has become effective pursuant to this paragraph.

(B) The commissioner may disapprove the change if the commissioner determines that the change would be detrimental to the interests of the contractholders participating in such separate accounts.

(7) Charges against separate account. The insurer must disclose in writing, prior to or contemporaneously with delivery of the contract, all charges that may be made against the separate account, including, but not limited to, the following:

(A) taxes or reserves for taxes attributable to investment gains and income of the separate account;

(B) actual cost of reasonable brokerage fees and similar direct acquisition and sale costs incurred in the purchase or sale of separate account assets;

(C) actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities. The tabular costs of insurance may not exceed the mortality rate for the attained age of the insured in the table specified for the calculation of cash surrender values in Insurance Code Chapter 1105, provided, for insurance issued on a substandard basis, the charge for mortality may be the mortality rate for the attained age of the insured in such other table as may be specified by the company and approved by the Texas Department of Insurance;

(D) charges for administrative expenses and investment management expenses, including internal costs attributable to the investment management of assets of the separate account;

(E) a charge, at a rate specified in the contract, for mortality and expense guarantees;

(F) any amounts in excess of those required to be held in the separate accounts;

(G) charges for incidental insurance benefits.

(8) Standards of conduct. Every insurer seeking approval to enter into the variable life insurance business in this state must adopt by formal action of its board of directors a written statement specifying the standards of conduct of the insurer, its officers, directors, employees, and affiliates with respect to the purchase or sale of investments of separate accounts. Such standards of conduct are binding on the insurer and those to whom it refers. A code of ethics meeting the requirements of 15 United States Code §80a-17, as amended, and applicable rules and regulations thereunder satisfies the provisions of this paragraph.

(9) Conflicts of interest. Rules under any provision of the Insurance Code or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest also apply to members of any separate account's committee or other similar body.

(10) Investment advisory services to a separate account. An insurer may not enter into a contract under which any person undertakes, for a fee, to regularly furnish investment advice to such insurer with respect to its separate accounts maintained for variable life insurance contracts unless:

(A) the person providing such advice is registered as an investment advisor under 15 United States Code §§80b-1-80b-21, as amended;

(B) the person providing such advice is an investment manager under 29 United States Code §1001, et seq., as amended, with respect to the assets of each employee benefit plan allocated to the separate account; or

(C) the insurer has filed with the commissioner and continues to file annually the following information and statements concerning the proposed advisor:

(i) the name and form of the organization, and its principal place of business;

(ii) the names and addresses of its partners, officers, directors, and persons performing similar functions or, if such an investment advisor be an individual, of such individual;

(iii) a written standard of conduct complying in substance with requirements of paragraph (8) of this section which has been adopted by the investment advisor and is applicable to the investment advisor, its officers, directors, and affiliates;

(iv) a statement provided by the proposed advisor as to whether the advisor or any person associated therewith:

(I) has been convicted within 10 years of any felony or misdemeanor arising out of such person's conduct as an employee, salesman, officer or director of an insurance company, a banker, an insurance agent, a securities broker, or an investment advisor involving embezzlement, fraudulent conversion, or misappropriation of funds or securities, or involving the violation of 18 United States Codes §§1341, 1342, or 1343, as amended;

(II) has been permanently or temporarily enjoined by an order, judgment, or decree of any court of competent jurisdiction from acting as an investment advisor, underwriter, broker, or dealer, or as an affiliated person or as an employee of any investment company, bank, or insurance company, or from engaging in or continuing any conduct or practice in connection with any such activity;

(III) has been found by federal or state regulatory authorities to have willfully violated or have acknowledged willful violation of any provision of federal or state securities laws or state insurance laws or of any rule or regulation under such laws; or

(IV) has been censored, denied an investment advisor registration, had a registration as an investment advisor revoked or suspended, or been

barred or suspended from being associated with an investment advisor by order of federal or state regulatory authorities; and

(D) such investment advisory contract must be in writing and provide that it may be terminated by the insurer without penalty to the insurer or the separate account upon no more than 60 days' written notice to the investment advisor. The commissioner may, after notice and opportunity for hearing, by order require such investment advisory contract to be terminated if the commissioner deems continued operation thereunder to be hazardous to the public or the insurer's contractholders.

§3.811. Savings Clause.

Each cause of action, pending litigation, or matter in process before the Texas Department of Insurance or commissioner of insurance will be determined in accordance with and governed by the applicable statutes, rules, orders, or interpretations of the Texas Department of Insurance in effect at the time of the occurrence of the subject event; and this section operates to save the application of such past procedure and law to any such event from amendment, change, or repeal, notwithstanding any provision of this subchapter or any conflict or ambiguity therein.

SUBCHAPTER J. REQUIRED REINSTATEMENT RELATING TO MENTAL INCAPACITY OF THE INSURED FOR INDIVIDUAL LIFE POLICIES WITHOUT NONFORFEITURE BENEFITS
28 TAC §3.909

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter J under Insurance Code §1106.010 and §36.001.

Insurance Code §1106.010 provides that the Commissioner adopt reasonable rules to implement Chapter 1106.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.909. Notification and Disclosure Requirements.

(a) The insurer is required to send notice of the conditions set forth in this subchapter under which the policy may qualify for reinstatement due to the mental incapacity of the insured. The notice must be sent to the owner of any individual life policy which does not provide nonforfeiture benefits if the policy is in force, renewed or issued on or after September 1, 1995. The notice required to be provided by this subsection must be provided within 90 days following lapse of an eligible policy.

(b) For all policies issued on or after September 1, 1995, disclosure of the conditions set forth in this subchapter under which the policy may qualify for reinstatement due to the mental incapacity of the insured may be made by incorporating the language of §3.913 of this title (relating to Notice and Disclosure Form), either in the policy or in an endorsement attached to the policy, in lieu of the notice requirements set forth in subsection (a) of this section.

(c) The notice required to be provided by this subsection will be deemed to be in compliance if mailed by first class mail to the last known address of the policyholder or if contained in the policy or included as an endorsement thereto.

(d) The notice required by this subsection must be provided in the form set forth in §3.913 of this title (relating to Notice and Disclosure Form).

SUBCHAPTER K. MAXIMUM GUARANTEED INTEREST RATES FOR ANNUITIES, PURE ENDOWMENT CONTRACTS, AND MISCELLANEOUS FUNDS
28 TAC §§3.1001, 3.1002, and 3.1006

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter K under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 specifies that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1001. Authority.

This subchapter is prescribed and promulgated in respect to the provisions of Insurance Code §982.114; Chapter 425, Subchapter B; Chapter 1701; Chapter 404; and other applicable provisions.

§3.1002. Purpose.

It is the purpose of this subchapter:

(1) to encourage a company's awareness that imprudent guarantees on annuity contracts and miscellaneous funds may lead to a hazardous financial condition, and to call attention of the fact that the commissioner of insurance may wish to make use of the early warning system;

(2) to provide for proper disclosure of benefits provided by annuity contracts and miscellaneous funds; and

(3) to clarify the interpretation of Insurance Code Chapter 425, Subchapter B, as it relates to the computation of reserves for annuity contracts and miscellaneous funds.

§3.1006. Early Warning Requirements.

The commissioner may, at the commissioner's discretion, require the data specified in this section from any insurance companies which are subject to this subchapter. These requirements apply to individual annuities, group annuities, and any supplemental provisions of riders attached to an individual life insurance policy or a group life insurance policy whenever on any valuation date contracts of the nature described are in force which guarantee interest rates in excess of the applicable maximum reserve valuation interest rate as defined by the Standard Valuation Law for that type of annuity or pure endowment contract to future premiums or other deposits of unspecified amounts or timing for or at any period of time subsequent to the valuation date. (Foreign companies will be required to furnish this data only with respect to their Texas issues.) Required data:

(1) number of individuals covered under such contracts;

(2) the actual premium received under such contracts during the 12 months preceding the applicable valuation date;

(3) the reserves held on such contracts on the valuation date; and

(4) an evaluation of the potential liability with respect to premiums or other deposits which may be received subsequent to the valuation date calculated in the following manner. Potential liability is the excess, if any, of the present value of the future cash value generated by "assumed future premiums" at the end of the last period of interest guarantees higher than the maximum reserve valuation rate as defined by the Standard Valuation Law for that type of annuity or pure endowment contract over the present value of "assumed future premiums" all valued at the maximum reserve valuation rate as defined by the Standard Valuation Law for that type of annuity or pure endowment contract. (If interest rate guarantees higher than the applicable maximum reserve valuation interest rate as defined by the Standard Valuation Law for that type of annuity

or pure endowment contract extend beyond attained age 70 of the applicable individual, then the present value of future cash values may be calculated at the 10th anniversary of the contract or on the anniversary nearest age 70, whichever is later.)

(A) "Assumed annual future premiums" must be level and equal in amount to the average annual premium received over the duration of the contract, counting any contract which is less than one year old as being a full year old.

(B) The assumed future payment period terminates on the earliest of the following:

(i) the end of the period during which guarantees are made regarding future premiums or deposits;

(ii) the end of the continuous period from date of valuation during which interest rates greater than the applicable maximum reserve valuation interest rate as defined in the Standard Valuation Law for that type of annuity or pure endowment contract;

(iii) the maturity date or retirement date specified in the contract; or

(iv) the later to occur of the 10th contract anniversary or the contract anniversary nearest age 65 of the prospective annuitant under the contract.

(C) Premium payments may be assumed to occur, at the choice of the company:

(i) annually on each July 1 succeeding the valuation date;

(ii) annually on the contract anniversary; or

(iii) monthly in the amount of 1/12th of the annual assumed premium, on a day of the month to be chosen by the company.

(D) If the probability of death is introduced into the above calculation, a statement of methods of application, including any subsequent changes,

must be filed with the Texas Department of Insurance along with a certification by a qualified actuary that introduction of such probability is appropriate to the contracts to which it is to be applied.

(E) Group methods and approximations which yield substantially the same potential liability valuation may be used.

(5) The validity of all such data and methods as specified in paragraphs (1) - (4) of this section must be attested to by the actuary signing the annual convention blank.

SUBCHAPTER L. STRENGTHENED RESERVES PURSUANT TO INSURANCE CODE §425.067
28 TAC §3.1101

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter L under Insurance Code §425.067 and §36.001.

Insurance Code §425.067 authorizes the Commissioner to establish categories of necessary reserves for certain policies, contracts, or benefits issued by life insurance companies.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1101. Strengthened Reserves Pursuant to Insurance Code §425.067.

A life insurance company may increase the amount of its reserve liabilities by changing the basis of computation as provided in Insurance Code §425.067. The insurer may establish a higher reserving basis by reporting an increase in reserve in Exhibit 5A of

its annual statement. Thereafter the insurer must continue to report on the higher basis. An insurer may, with the approval of the Texas Department of Insurance, as provided in Insurance Code §425.067, adopt a lower standard of valuation, but not lower than the minimum standard provided in Insurance Code §425.053.

SUBCHAPTER N. NONFORFEITURE STANDARDS FOR INDIVIDUAL LIFE INSURANCE IN EMPLOYER PENSION PLANS
28 TAC §§3.1303 - 3.1305

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter N under Insurance Code §§425.073, 541.057, 541.401, 1105.055(h), and 36.001.

Insurance Code §425.073 requires the Commissioner to adopt by rule a valuation manual and to determine the operative date of the manual.

Insurance Code §541.057 prohibits unfair discrimination in the rates charged, dividends or benefits payable, or any other contract terms and conditions for individuals of the same class and equal life expectancy in life insurance and annuity contracts.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1105.055(h) specifies that the Commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1303. Standard.

(a) For any policy of insurance on the life of either a male or female insured, delivered, or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057), and before January 1, 2017, for that policy form, the following tables described in paragraphs (1) and (2) of this subsection may be used as specified in subsection (b) of this section in determining minimum cash surrender values, amounts of paid up nonforfeiture benefits, or benefits under extended term insurance provisions included in the policy. For policies issued on or after January 1, 2017, the valuation manual, adopted under Insurance Code Chapter 425, Subchapter B, provides the tables to be used.

(1) A mortality table which is a blend of the 1980 CSO Table (M) and 1980 CSO Table (F), with or without Ten-Year Select Mortality Factors, may, at the option of the company, be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors.

(2) A mortality table which is of the same blend as used in paragraph (1) of this subsection, but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F), may, at the option of the company, be substituted for the 1980 CET Table.

(b) The following tables are to be considered as the basis for acceptable tables:

(1) 100% male, 0% female for tables to be designated as the "1980 CSO-A" and "1980 CET-A" Tables;

(2) 80% male, 20% female for tables to be designated as the "1980 CSO-B" and "1980 CET-B" Tables;

(3) 60% male, 40% female for tables to be designated as the "1980 CSO-C" and "1980 CET-C" Tables;

(4) 50% male, 50% female for tables to be designated as the "1980 CSO-D" and "1980 CET-D" Tables;

(5) 40% male, 60% female for tables to be designated as the "1980 CSO-E" and "1980 CET-E" Tables;

(6) 20% male, 80% female for tables to be designated as the "1980 CSO-F" and "1980 CET-F" Tables; and

(7) 0% male, 100% female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" Tables.

(c) Values of 1,000 qx for the blended tables as specified in subsection (b)(2) - (6) of this section can be found in "Proceedings of the NAIC," Volume 1, 1984, pages 396 - 400. "Proceedings of the NAIC," Volume 1, 1984, page 457, shows the method by which ten-year select mortality factors may be obtained. The tables specified in subsection (b)(1) of this section are the same as the 1980 CSO Table (M) or the 1980 CET Table (M), as applicable. The tables specified in subsection (b)(7) of this section are the same as the 1980 CSO Table (F) or the 1980 CET Table (F), as applicable. The tables specified in subsection (b)(2) - (6) of this section are adopted herein by reference. Copies of those tables may be obtained by contacting Texas Department of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030, Austin, Texas 78711-2030. The tables in subsection (b)(1) and (7) of this section are already adopted by statutory law under alternate names.

(d) The tables specified in subsection (b)(1) and (7) of this section may not be used with respect to policies issued on or after January 1, 1985, except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other or except for certain policies converted from group insurance. Such group conversions issued on or after January 1, 1986, must use mortality tables based on the blend of lives by sex expected for such policies if such group conversions are considered as extensions of the decision in *Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris*, 103 S. Ct. 3492 (1983). This consideration has not been

clearly defined by court or legislative action in all jurisdictions, as of the date of promulgation of this section.

(e) Notwithstanding any other provision of this subchapter, an insurer may not use these blended tables unless the *Norris* decision is known to apply to the policies involved, or unless there exists a bona fide concern on the part of the insurer that the *Norris* decision might reasonably be construed to apply by a court having jurisdiction.

§3.1304. Alternate Rule.

(a) In determining minimum cash surrender value and amounts of paid-up nonforfeiture benefits for any policy of insurance on either a male or a female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057), and before January 1, 2017, for that policy form, in addition to the mortality tables that may be used according to §3.1303 of this title (relating to Standard), the tables in paragraphs (1) and (2) of this subsection may be used. For policies issued on or after January 1, 2017, the valuation manual, adopted under Insurance Code Chapter 425, Subchapter B, provides the tables to be used.

(1) A mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without 10-year select mortality factors, may at the option of the company be substituted for the 1908 CSO Table, with or without 10-year select mortality factors.

(2) A mortality table which is of the same blend as used in paragraph (1) of this subsection but applied to form a blend of the male and female rates of mortality

according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table or 1980 CET Nonsmoker Mortality Table may, at the option of the company, be substituted for the 1980 CET Table.

(b) The following blended mortality tables are considered as the basis for acceptable tables according to subsection (a) of this section:

(1) 100% male, 0% female for smoker tables to be designated as the 1980 CSO-SA and 1980 CET-SA Tables;

(2) 80% male, 20% female for smoker tables to be designated as the 1980 CSO-SB and 1980 CET-SB Tables;

(3) 60% male, 40% female for smoker tables to be designated as the 1980 CSO-SC and 1980 CET-SC Tables;

(4) 50% male, 50% female for smoker tables to be designated as the 1980 CSO-SD and 1980 CET-SD Tables;

(5) 40% male, 60% female for smoker tables to be designated as the 1980 CSO-SE and 1980 CET-SE Tables;

(6) 20% male, 80% female for smoker tables to be designated as the 1980 CSO-SF and 1980 CET-SF Tables;

(7) 0% male, 100% female for smoker tables to be designated as the 1980 CSO-SG and 1980 CET-SG Tables;

(8) 100% male, 0% female for nonsmoker tables to be designated as the 1980 CSO-NA and 1980 CET-NA Tables;

(9) 80% male, 20% female for nonsmoker tables to be designated as the 1980 CSO-NB and 1980 CET-NB Tables;

(10) 60% male, 40% female for nonsmoker tables to be designated as the 1980 CSO-NC and 1980 CET-NC Tables;

(11) 50% male, 50% female for nonsmoker tables to be designated as the 1980 CSO-ND and CET-ND Tables;

(12) 40% male, 60% female for nonsmoker tables to be designated as the 1980 CSO-NE and 1980 CET-NE Tables;

(13) 20% male, 80% female for nonsmoker tables to be designated as the 1980 CSO-NF and 1980 CET-NF Tables; and

(14) 0% male, 100% female for nonsmoker tables to be designated as the 1980 CSO-NG and 1980 CET-NG Tables.

(c) The Texas Department of Insurance adopts and incorporates into this subchapter by reference the tables to which subsection (b) of this section refers as tables to be used in conjunction with the section adopted under this subchapter. Copies of these tables can be obtained from the Texas Department of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030, Austin, Texas 78711-2030.

(d) The tables specified in subsection (b)(1), (7), (8), and (14) of this section may not be used except where the proportion of persons insured is anticipated to be 90% or more of one sex or the other.

(e) Notwithstanding any other provision of this subchapter, an insurer may not use the blended mortality tables in subsection (b) of this section unless the *Norris* decision is known to apply to the policies involved, or unless there exists a bona fide concern on the part of the insurer that the *Norris* decision might reasonably be construed to apply by a court having jurisdiction.

§3.1305. Unfair Discrimination.

It is not a violation of Insurance Code §541.057 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis, as permitted by this subchapter.

SUBCHAPTER O. SMOKER-NONSMOKER COMPOSITE MORTALITY TABLES
28 TAC §3.1403 and §3.1404

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter O under Insurance Code §§541.057, 541.401, 1105.055(h), and 36.001.

Insurance Code §541.057 prohibits unfair discrimination in the rates charged, dividends or benefits payable, or any other contract terms and conditions for individuals of the same class and equal life expectancy in life insurance and annuity contracts.

Insurance Code §541.401 provides that the Commissioner may adopt and enforce reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1105.055(h) specifies that the Commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1403. Alternate Tables.

(a) For any policy of insurance delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057), for that policy form and before January 1, 1989, at the option of the company and subject to the conditions stated in §3.1404 of this title (relating to Conditions):

(1) the 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) the 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(b) The tables specified in subsection (a) of this section must be used as described in subsection (a) of this section to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision. Provided, however, that for any category of insurance issued on female lives with minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision determined using 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided further that the substitution of the 1958 CSO or CET Smoker and Nonsmoker Mortality Tables is available only if made for each policy of insurance on a policy form delivered or issued for delivery on or after the operative date for that policy form and before a date not later than January 1, 1989.

(c) For any policy of insurance delivered or issued for delivery in this state after the operative date of former Insurance Code Article 3.44a, §8 (recodified in Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057), for the policy form, at the option of the company and subject to the conditions stated in §3.1404 of this title (relating to Conditions):

(1) the 1980 CSO Smoker and Nonsmoker Mortality Tables, with or without Ten-Year Select Mortality Factors, may be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

(2) the 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(d) The tables specified in subsection (c) of this section must be used as provided in subsection (c) of this section to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid up nonforfeiture benefits, or benefits under any extended term insurance provision.

(e) Values of 1,000 qx for the tables specified in this section can be found in "Proceedings of the NAIC," Volume I, 1984, pages 402 - 413. These tables are adopted herein by reference for use in an appropriate manner as described in this subchapter. Copies may be obtained by contacting the Texas Department of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030, Austin, Texas 78711-12030. These tables are more particularly identified as follows:

(1) 1958 CSO Nonsmokers and Smokers Mortality Tables;

(2) 1958 CET Nonsmokers and Smokers Mortality Tables;

(3) 1980 CSO Female Nonsmokers and Smokers Mortality Tables;

(4) 1980 CSO Male Nonsmokers and Smokers Mortality Tables;

(5) 1980 CET Female Nonsmokers and Smokers Mortality Tables; and

(6) 1980 CET Male Nonsmokers and Smokers Mortality Tables.

§3.1404. Conditions.

For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may:

(1) use composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits or benefits under any extended term insurance provision;

(2) use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Insurance Code §425.068, and use composite mortality tables to determine the basic minimum reserves,

minimum cash surrender values, and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision; or

(3) use smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, or benefits under any extended term insurance provision.

SUBCHAPTER Q. ACTUARIAL OPINION AND MEMORANDUM REGULATION 28 TAC §§3.1601, 3.1602, 3.1605, 3.1606, and 3.1607

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter Q under Insurance Code §§425.054, 425.073, and 36.001.

Insurance Code §425.054 provides that the Commissioner specify by rule the requirements of an actuarial opinion under §425.054(b), including any matters considered necessary to the opinion's scope.

Insurance Code §425.073 requires the Commissioner to adopt by rule a valuation manual and to determine the operative date of the manual.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1601. Purpose.

The purpose of this subchapter is to prescribe guidelines and standards for the activities described in paragraphs (1) - (3) of this section:

(1) the submission of a statement of actuarial opinion in accordance with Insurance Code §425.054 and for memoranda in support of such opinion;

(2) the appointment of an appointed actuary; and

(3) guidance as to the meaning of "adequacy of reserves."

§3.1602. Scope and Applicability.

(a) This subchapter shall apply to all life insurance companies doing business in this state and to all life insurance companies which are authorized to reinsure life insurance, annuities or accident and health insurance business in this state.

(b) This subchapter 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 commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's judgment, these specifications are necessary for an acceptable opinion to be rendered relative to the adequacy of reserves and related items.

(c) This subchapter applies to the actuarial opinion for the 2005 valuation through the 2016 valuation. The requirements of the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, apply to actuarial opinions for valuations on or after January 1, 2017.

(d) A statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with §3.1606 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis), and a memorandum in support thereof in accordance with §3.1607 of this title (relating to Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary), shall be required each year, unless exempt under §3.1608 of this title (relating to Asset Adequacy Analysis Exemption).

§3.1605. General Requirements.

(a) Submission of statement of actuarial opinion. Any statement of actuarial opinion required by this subchapter must be submitted in accordance with paragraphs (1) and (2) of this subsection.

(1) There is to be included on or attached to page one of the annual statement for each year beginning with the year in which this subchapter 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 §3.1606 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis).

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

(b) Appointment of actuary. The company must give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and must state in the notice that the person is a qualified actuary. Once notice is furnished, no further notice is required with respect to this person, provided that the company gives the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements for a qualified actuary. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice must so state and give the reasons for replacement.

(c) Standards for asset adequacy analysis. The asset adequacy analysis required by this subchapter must:

(1) conform to the Standards of Practice as promulgated from time to time by the Actuarial Standards Board and any additional standards set forth in this subchapter,

which standards are to form the basis of the statement of actuarial opinion in accordance with this subchapter; and

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

(d) Liabilities to be covered. The liabilities to be covered will be in accordance with paragraphs (1) - (3) of this subsection.

(1) Under authority of Insurance Code §425.054, the statement of actuarial opinion applies to all in-force business on the statement date, whether directly issued or assumed, regardless of when or where issued, for example, annual statement reserves in Exhibits 5, 6, and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or statements.

(2) 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 Insurance Code §§425.064, 425.065, 425.068, and 425.069, and other applicable Insurance Code provisions, the company must establish the additional reserve.

(3) Additional reserves established under paragraph (2) of this subsection and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the actuarial opinion for the applicable year. The release of such reserves would not be deemed an adoption of a lower standard of valuation.

§3.1606. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis.

(a) General description. The statement of actuarial opinion required by this section must consist of the following paragraphs:

(1) a paragraph identifying the appointed actuary and his or her qualifications, recommended language is provided in subsection (b)(1) of this section;

(2) a scope paragraph (recommended language is provided in subsection (b)(2) of this section) 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 that have been analyzed for asset adequacy and the method of analysis, and identifying the reserves and related actuarial items covered by the opinion that have not been so analyzed;

(3) a reliance paragraph (recommended language is provided in subsection (b)(3) of this section) 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), supported by a statement of each such expert with the information prescribed by subsection (e) of this section; and

(4) an opinion paragraph expressing the appointed actuary's opinion with respect to the adequacy of the supporting assets to mature the liabilities (recommended language is provided in subsection (b)(6) of this section).

(5) One or more additional paragraphs will be needed in individual company cases as follows:

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

(B) 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;

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

(D) if the appointed actuary chooses to add a paragraph briefly describing the assumptions that form the basis for the actuarial opinion.

(b) Recommended language. The following paragraphs are to be included in the statement of actuarial opinion in accordance with this section. The language is that which should be included in typical circumstances 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 or her professional judgment. Regardless of the language used, the opinion must retain all pertinent aspects of the language provided in this section.

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

(A) For a company actuary, the opening paragraph of the actuarial opinion should include a statement such as:

Figure: 28 TAC §3.1606(b)(1)(A)

"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 commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(B) For a consulting actuary, the opening paragraph should include a statement such as:

Figure: 28 TAC §3.1606(b)(1)(B)

"I, (name), a member of the American Academy of Actuaries, am associated with the firm of (name of consulting firm). I have been

appointed by, or by the authority of, the Board of Directors of (name of company) to render this opinion as stated in the letter to the commissioner dated (insert date). I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and health insurance companies."

(2) The scope paragraph should include a statement such as:

Figure: 28 TAC §3.1606(b)(2)

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20( ). Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis.

Asset Adequacy Tested Amounts--Reserves and Liabilities

Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (*) (2)	Analysis Method (**)	Other Amount (3)	Total Amount (1)+(2)+(3) (4)
Exhibit 5 Life Insurance					
Annuities					
Supplementary Contracts With Life Contingencies					
Accidental Death Benefits					
Disability - Active Lives					
Disability - Disabled Lives					
Miscellaneous Reserves					
Total Exhibit 5 (Page 3, Line 1)					
Exhibit 6 Active Life Reserve					
Claim Reserve					

Total Exhibit 6 (Page 3, Line 2)					
Exhibit 7 Guaranteed Interest Contracts Column 2, Line 14					
Annuities Certain Column 3, Line 14					
Supplemental Contracts Column 4, Line 14					
Dividend Accumulations or Refunds Column 5, Line 14					
Premium and Other Deposit Funds Column 6, Line 14					
Total Exhibit 7 Column 1, Line 14 (Page 3, Line 3)					
Exhibit 8, Part 1 Life (Page 3, Line 4.1)					
Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1 Column 1, Line 4.4					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1, 2, 3.1, 3.2, 3.3)					
TOTAL RESERVES					

IMR (General Account, Page ___ Line ___)	
(Separate Accounts, Page ___ Line ___)	
AVR (Page ___ Line ___)	(***)
Net Deferred and Uncollected Premium	

Notes:

(*) The additional actuarial reserves are the reserves established under §3.1605(d)(2) of this title (relating to General Requirements).

(**) The appointed actuary should indicate the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in §3.1605(c) of this title, by means of symbols that should be defined in footnotes to the table.

(***) Allocated amount of AVR.

(3) 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:

Figure: 28 TAC §3.1606(b)(3)

"I have relied on (name), (title) for (e.g., "anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios" or "certain critical aspects of the analysis performed in conjunction with forming my opinion"), as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts should be accompanied by a statement by each of the experts with the information prescribed by subsection (e) of this section.

(4) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph should include a statement such as:

Figure: 28 TAC §3.1606(b)(4)

"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."

(5) If the appointed actuary has not examined the underlying records, but has relied upon data (e.g., listings and summaries of policies in force or asset records) prepared by the company, the reliance paragraph should include a statement such as:

Figure: 28 TAC §3.1606(b)(5)

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

The reliance paragraph shall be accompanied by a statement by each person relied upon with the information prescribed by subsection (e) of this section.

(6) The opinion paragraph should include a statement such as:

Figure: 28 TAC §3.1606(b)(6)

"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 that 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 regulation 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); and

{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 the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

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

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

or

The following material changes 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.)

Choose whichever of the two immediately preceding paragraphs is appropriate.

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"

(c) Assumptions for new issues. The adoption for new issues or new claims or other new liabilities of an actuarial assumption that 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.

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

(e) Reliance on information 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 must provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness, or reasonableness, as applicable, of the items. This certification must include the signature, title, company, address, email address, and telephone number of the person rendering the certification, as well as the date on which it is signed.

(f) Alternate option.

(1) Insurance Code Chapter 425, Subchapter B, gives the commissioner 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 subsection (b)(6) of this section, the commissioner may make one or more of the following additional approaches available to the opining actuary:

(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 commissioner chooses to allow this alternative, a formal written list of standards and conditions must be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year apply to statements for that calendar year and remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(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 commissioner for approval of that request have been met." If the commissioner chooses to allow this alternative, a formal written statement of such allowance must be issued no later than March 31 of the year it is first effective. It will remain valid until rescinded or modified by the commissioner. The

rescission or modifications must 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 must 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 will be deemed approved on October 1 of that year if the commissioner has not denied the request by that date.

(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."

(i) If the commissioner chooses to allow this alternative, a formal written list of products (to be added to the table in Figure: 28 TAC §3.1606(f)(1)(C)(ii)) for which the required comparison must be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year apply to statements for that calendar year and remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

(ii) If a company desires to use this alternative, the appointed actuary must provide a comparison of the gross nationwide reserves held to the gross nationwide reserves that would be held under §7.18 of this title (relating to NAIC Accounting Practices and Procedures Manual). 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 must be at least:

Figure: 28 TAC §3.1606(f)(1)(C)(ii)

(1) Product Type	(2) Death Benefit or Account Value	(3) Reserves Held	(4) Codification Reserves	(5) Codification Standard

(iii) The information listed must include all products identified by either the state of filing or any other states subscribing to this alternative.

(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 must provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(2) The commissioner 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 60 days of the request or such other period of time determined by the commissioner after consultation with the company, the commissioner may contract with an independent actuary at the company's expense to prepare and file the opinion.

§3.1607. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary.

(a) General. Any actuarial memorandum required by the provisions of this subchapter must be prepared in accordance with and subject to the provisions and qualifications of paragraphs (1) - (5) of this subsection.

(1) In accordance with Insurance Code §§425.054 - 425.057, the appointed actuary must prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves under the opinion. The memorandum must be made available for examination by the commissioner upon the commissioner's request.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of §3.1604 of this title (relating to Definitions), with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the commissioner requests a memorandum and no such memorandum exists or if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board as required by §3.1605 of this title (relating to General Requirements), or the standards and requirements of this subchapter, the commissioner 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 must be paid by the company but will be directed and controlled by the commissioner.

(4) The reviewing actuary will 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 will be retained by the commissioner. The reviewing actuary may not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer required by this subchapter for any one of the current year or the preceding three years.

(5) In accordance with Insurance Code §§425.054 - 425.057, the appointed actuary must prepare a regulatory asset adequacy issues summary, the contents of which

are specified in subsection (c) of this section. Texas domestic companies must submit the regulatory asset adequacy issues summary by email to ActuarialDivision@tdi.texas.gov or by paper copy to the Texas Department of Insurance, Financial Regulation Division, MC-FRD, P.O. Box 12030, Austin, Texas 78711-2030 no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. Nondomestic companies must submit the regulatory asset adequacy issues summary when requested by the commissioner.

(b) Details of the memorandum section documenting asset adequacy analysis. When an actuarial opinion under §3.1606 of this title (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis) is provided, the memorandum must demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in §3.1605(c) of this title and any additional standards under this subchapter. The documentation of the assumptions used in paragraphs (1) and (2) of this subsection must be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. The memorandum must specify:

(1) for reserves:

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

(B) source of liability in force;

(C) reserve method and basis;

(D) investment reserves;

(E) reinsurance arrangements;

(F) 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;

(G) documentation of assumptions to test reserves for the following:

(i) lapse rates (both base and excess);

(ii) interest crediting rate strategy;

(iii) mortality;

(iv) policyholder dividend strategy;

(v) competitor or market interest rate;

(vi) annuitization rates;

(vii) commissions and expenses; and

(viii) morbidity.

(2) For assets:

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

(B) investment and disinvestment assumptions;

(C) source of asset data;

(D) asset valuation bases; and

(E) documentation of assumptions made for:

(i) default costs;

(ii) bond call function;

(iii) mortgage prepayment function;

(iv) determining market value for assets sold due to disinvestment strategy; and

(v) determining yield on assets acquired through the investment strategy.

(3) For the analysis basis:

(A) methodology;

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

(C) rationale for degree of rigor in analyzing different blocks of business (including the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(D) criteria for determining asset adequacy (including the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

(E) whether the impact of federal income taxes was considered and the method of treating reinsurance in the asset adequacy analysis;

(4) summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;

(5) summary of results; and

(6) conclusions.

(c) Details of the regulatory asset adequacy issues summary.

(1) The regulatory asset adequacy issues summary must include:

(A) 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 must 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.

(B) 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.

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

(D) comments on any interim results that may be of significant concern to the appointed actuary. For example, the comments must describe 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.

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

(F) 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.

(2) The regulatory asset adequacy issues summary must contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and be signed and dated by the appointed actuary rendering the actuarial opinion.

(3) The regulatory asset adequacy issues summary will be used to examine the company's financial condition and ability to meet its liabilities. It will be considered information obtained during the course of an examination under the Insurance Code Chapter 401 and treated as confidential.

(d) Conformity to standards of practice. The memorandum must include a statement with wording substantially similar to that of this subsection as follows: "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."

(e) Use of assets supporting the IMR and the AVR. An appropriate allocation of assets in the amount of the 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 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.

(f) Documentation retention. The appointed actuary must retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions, and the results obtained.

SUBCHAPTER R. LIFE SETTLEMENT
DIVISION 2. LICENSE APPLICATION AND RENEWAL; COURSE AND TRAINING REQUIREMENTS; MAINTENANCE OF RECORDS
28 TAC §3.1720

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter R, Division 2, under Insurance Code §1111A.015 and §36.001.

Insurance Code §1111A.015 authorizes the Commissioner to adopt rules to implement Chapter 1111A and regulate the activities and relationships of providers, brokers, insurers, and their authorized representatives.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1720. Forms.

(a) Application form. The commissioner adopts by reference the License Application for a Life Settlement Provider or Broker form (revised April 2013) as the application for license for each person engaging in, or desiring to engage in, business as a life settlement broker or life settlement provider in this state.

(b) Renewal, Surrender, or Change of Information form. The commissioner adopts by reference the Application for Renewal, Surrender, or Change of Information for a Life Settlement Provider or Broker form (revised April 2013) for the renewal, nonrenewal, or surrender of life settlement broker or provider licenses and for use in providing notice to the department of a change to any license holder information or information in an application previously submitted to the department.

(c) Life Agent Notification form. The commissioner adopts by reference the Life Agent Notification to TDI to Act as a Life Settlement Broker form (revised March 2013) for use by a life insurance agent operating as a life settlement broker.

(d) Biographical Affidavit form. The commissioner adopts by reference the Biographical Affidavit for Life Settlement Providers or Brokers form (revised April 2013) for use as an attachment to the License Application for a Life Settlement Provider or Broker form and as an attachment to the Application for Renewal, Surrender, or Change

of Information for a Life Settlement Provider or Broker form, as applicable, for each owner, partner, director, officer, key management personnel, employee having authority to direct the management of the organization, and any person who has ownership of 10% or greater of the applicant or the applicant's stock.

(e) Where to find and send forms. The forms adopted in this section may be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or obtained at the department's website at www.tdi.texas.gov/forms.

SUBCHAPTER R. LIFE SETTLEMENT
DIVISION 3. FORM FILING AND USAGE REQUIREMENTS
28 TAC §3.1740 and §3.1742

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter R, Division 3, under Insurance Code §1111A.015 and §36.001.

Insurance Code §1111A.015 authorizes the Commissioner to adopt rules to implement Chapter 1111A and regulate the activities and relationships of providers, brokers, insurers, and their authorized representatives.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1740. Form Filing Requirements and Approval, Disapproval, or Withdrawal of Forms; Fees.

(a) General form filing requirement. A person must not use a form used to effectuate a life settlement in this state unless the form has been filed with and approved

by the commissioner under this section, if prior approval is required by subsection (f) of this section.

(b) Required life settlement contract form filings. Forms that must be filed include the following:

(1) settlement contracts, including any amendments;

(2) disclosures;

(3) verification of coverage forms;

(4) escrow or trust agreements;

(5) documents used to obtain or release confidential information, including documents used by the life settlement broker or provider that in any way refer to, affect, request, or relate to a life settlement broker or provider obtaining or releasing confidential information;

(6) owner consent forms;

(7) power of attorney forms;

(8) settlement applications;

(9) premium finance loan documents as specified in Insurance Code §1111A.002(11)(B), unless exempted by §1111A.002(11-A); and

(10) any other form used by a life settlement broker or provider to effectuate a life settlement contract in this state.

(c) Submission. Licensees must submit one copy of forms as required by this section. Non-electronic filings must be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. A filing submitted electronically must be submitted through the System for Electronic Rate and Form Filing. A person must hold a life settlement broker's or provider's license issued by the department, have authority to operate as a life settlement broker, or be authorized under subsection (d)(2) of this section to submit forms.

(d) Transmittal checklist requirement. The commissioner adopts by reference the Transmittal Checklist for Life/Health Rate and Form Filings (revised May 2013) to be filed with and attached to forms filed pursuant to subsection (c) of this section. The form may be obtained from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030 or by accessing the department's website at www.tdi.texas.gov/forms. The transmittal checklist must provide complete and accurate information about the filing, be signed by a duly authorized representative or attorney of the life settlement broker or provider, and include the following information:

(1) the name and license number of the submitting life settlement broker or provider;

(2) a designated contact person for the filing, including the individual's name, address, phone number, and, if available, fax number, and email address. If the form filing is submitted by anyone other than the life settlement broker or provider, the filing must include an attachment executed by the life settlement broker or provider, or by an officer of an entity, that designates the person submitting the filing as the contact for that filing;

(3) a list of all submitted forms and an explanation of the purpose and use of each form;

(4) if applicable, a list of the form numbers and approval dates of all previously reviewed forms with which the submitted form will be used and a statement explaining when the submitted form will be used;

(5) a designation indicating the type of filing, as those types are described in subsection (h) of this section; and

(6) any applicable information, attachments, and certifications specified in this section.

(e) Specific form filing requirements. Forms filed pursuant to this section are subject to the requirements set forth in paragraphs (1) - (3) of this subsection.

(1) Any form filed pursuant to this section must:

(A) prominently display the full name, home office mailing address, and telephone number, and email address, if available, of the life settlement broker or provider;

(B) include specimen language and specimen fill-in material. A broker or provider is prohibited from including the confidential information of any policy owner in the filed form. Fill-in lines, blanks, and text boxes that are clearly titled with the information to be filled in do not require specimen language;

(C) be submitted on 8-1/2-by-11-inch paper or formatted for that size if submitted electronically. The department will not accept bound forms;

(D) be submitted in typewritten, computer-generated, or printer's proof format and be clearly legible;

(E) include a unique form number designation sufficient to distinguish it from all other forms used by the life settlement broker or provider. The form number must be located in the lower left-hand corner of the cover page or on the first page of the form, if visible with the cover closed; and

(F) a designation indicating whether the form is filed as file and use or review and approval prior to use as those categories are described in subsection (f) of this section.

(2) A form filed under this section may contain variable language, provided the variable language is both bracketed and accompanied by a clear explanation of how the material will vary and how it will be used.

(3) The department will not accept handwritten forms or handwritten corrections.

(f) Categories for form filings.

(1) Review and approval prior to use; deemer. A life settlement broker or provider must file life settlement contract forms, disclosures, and verification of coverage forms under this paragraph with the department not less than 60 days prior to the life settlement broker's or provider's use or delivery of such form. After the submission of a filing under this subsection, the life settlement broker or provider may not use or deliver the form on or before 60 days from the date the department receives the form unless the department approves the form during the 60-day period. If the department has not approved the form by the 60th day after the date the department receives the form, the life settlement broker or provider may deem the form approved only if:

(A) the life settlement broker or provider has not requested an extension or waiver of the review period; and

(B) the department has not disapproved the form.

(2) File and use. A life settlement broker or provider may immediately use and deliver a form filed under this category in this state until the department makes a request for corrections or disapproves the form. A life settlement broker or provider may file any other form identified in subsection (b)(4) - (10) of this section under this paragraph. A filing under this category must include the information and certifications specified in subsection (i)(1) and (2) of this section. Any form that the department has previously disapproved pursuant to subsection (k) of this section is not eligible for filing under this category.

(3) Forms approved prior to the effective date of this section. Forms approved prior to the effective date of this section must comply with this subchapter six months from the effective date of this section.

(g) Extension or waiver of review period. A request for extension of time for the approval of a form must comply with paragraphs (1) - (5) of this subsection.

(1) A life settlement broker or provider may request in writing an extension to the approval period for a form for an additional period not to exceed 45 days.

(2) The department automatically grants a timely request for extension under this section on the date it receives the request.

(3) The department will only grant one extension under this section.

(4) If the department grants an extension under this section and does not affirmatively approve or disapprove the form before the extended period expires, the form is considered approved on the first day after the date the extended period expires.

(5) A life settlement broker or provider may waive the deeming of the form filings.

(h) Types of form filings. The types of life settlement contract form filings available for designation on the transmittal checklist are as follows:

(1) New form. A form that the department has not previously reviewed or approved under Insurance Code §1111A.005 and this subchapter, except for a form withdrawn by a life settlement broker or provider pursuant to paragraph (6) of this subsection.

(2) Informational form. A form submitted for informational purposes only.

(3) Substantially similar to a previously approved form. A form that is substantially similar to a form that the department reviewed or approved on or after the effective date of this subchapter. This type of form filing requires the information and certification specified in subsection (i)(1), (2), and (4) of this section.

(4) Exact copy. A form that, except for the life settlement broker's or provider's name, address, phone number, or other similar life settlement broker's or provider's identification information, is an exact copy of a form the department reviewed or approved on or after the effective date of this subchapter. This type of form filing

requires the information and certifications specified in subsection (i)(1) and (4) of this section and is approved as of the date the department receives it.

(5) Substitution for a previously approved form. A form that is a substitute for a form the department previously reviewed or approved on or after the effective date of this subchapter for the same life settlement broker or provider, provided that the broker or provider has not issued or otherwise used the previously reviewed or approved form in Texas and will not use it in Texas at any time. This type of form filing requires the information and certifications specified in subsection (i)(1) and (4) of this section.

(6) Correction to a pending form. A form containing corrections to a pending form submitted subsequent to the life settlement broker or provider receiving notification of the pending form's deficiencies from the department. This type of form filing requires the information and certifications specified in subsection (i)(1) and (5) of this section. The department must receive the filing no later than 30 days following the date the life settlement broker or provider receives written notification from the department of the form's deficiencies. The department will consider the originally submitted form withdrawn if it does not receive a corrected form within 30 days following the date the notification of the form's deficiencies is sent. The department will not approve or review a withdrawn form until the broker or provider refiles it as a new form filing.

(7) Resubmission of a previously disapproved form. A form containing corrections to a form subsequent to the life settlement broker or provider receiving a disapproval letter from the department. This type of form filing requires the information and certifications specified in subsection (i)(1) and (7) of this section.

(i) Certifications, attachments, and other information. A life settlement broker or provider must include in a filing the certifications, attachments, and other information referred to in this section as follows:

(1) A life settlement broker or provider, or the broker's or provider's duly authorized representative or attorney, filing any form with the department must certify on the transmittal checklist that:

(A) the filer has reviewed and is familiar with all applicable statutes and regulations of this state;

(B) the filer has reviewed the form filing; and

(C) to the best of the filer's knowledge and belief, the filed form complies in all respects with the applicable statutes and regulations of this state.

(2) A life settlement broker or provider filing a form as file and use under subsection (f)(2) of this section must, in addition to providing the certification specified in paragraph (1) of this subsection, certify that:

(A) no corrections to the form have been requested by the department; and

(B) the form has not been previously disapproved by the department.

(3) A life settlement broker or provider filing a form as review and approval prior to use under subsection (f)(1) of this section must, in addition to providing the certification specified in paragraph (1) of this subsection, certify that it will not use the form until the department approves it. If, following the 60th day from the date the department receives the form, the life settlement broker or provider elects to use, issue, or deliver such form prior to receiving approval from the department, the life settlement broker or provider must have provided the certifications specified in paragraphs (1) and (2) of this subsection.

(4) A life settlement broker or provider submitting a form under subsection (h)(3), (4), or (5) of this section must provide the certification specified in paragraph (1) of this subsection, in addition to the following information and certification:

(A) the form number and approval date of the previously approved form, including the broker's or provider's name if different from the submitting broker or provider;

(B) a summary of the differences between the previously approved form and the submitted form, including a description of any deleted text. The submitted form must clearly identify all changes, with new or modified text underlined; and

(C) a certification that the form contains no changes other than those identified.

(5) A life settlement broker or provider submitting a form pursuant to subsection (h)(6) of this section must provide the certification specified in paragraph (1) of this subsection, in addition to the following information and certification:

(A) the form number of the pending form;

(B) the name of the department's form review specialist who reviewed the form;

(C) the date of notification of any form deficiencies;

(D) the tracking number of the pending form assigned by the department;

(E) a summary of the differences between the previously reviewed form and the corrected form, including a description of any deleted text. The corrected form must clearly identify all changes, with new or modified text underlined; and

(F) a certification that the form contains no changes other than those identified.

(6) A life settlement broker or provider submitting a form pursuant to subsection (h)(5) of this section must provide the certification specified in paragraph (1) of this subsection and a certification that the broker or provider has not issued or used the original version of the form in Texas and will not use it in Texas at any time.

(7) A life settlement broker or provider submitting a form pursuant to subsection (h)(7) of this section must provide:

(A) a certification specified in paragraph (1) of this subsection, as well as the information and certifications specified in paragraph (5)(B), (D), (E), and (F) of this subsection;

(B) the form number of the disapproved form; and

(C) the date of disapproval by the department.

(j) Forms not qualified for review. The department will not accept for review and will return to the life settlement broker or provider form filings that are not accompanied by a completed transmittal checklist or that do not contain all required information or certifications. No filing fees will be refunded.

(k) Disapproval or withdrawal of previous approval; request for corrections. Form disapprovals, withdrawals of previous approvals, and requests for corrections to filed forms subject to paragraphs (1) and (2) of this subsection.

(1) The department may disapprove, withdraw previous approval, or request that a life settlement broker or provider make corrections of any form filed pursuant to this section if the form:

(A) fails to comply with any applicable statutes or regulations of this state;

(B) fails to meet any requirements of the Insurance Code, including §§1111A.011, 1111A.012, 1111A.014, and 1111A.023(b);

(C) is unreasonable or contrary to the interests of the public; or

(D) is otherwise misleading or unfair to the owner.

(2) When the department makes a request for corrections, disapproves a form, or withdraws approval of a form pursuant to this section, the department may

require that the life settlement broker or provider discontinue using the form, replace the form, or any other appropriate remedy available by law.

(l) Notification of approval or disapproval. The department will provide written notification of any approval or disapproval of any form filed under this section.

(m) Additional requested information. The department may request any additional information necessary for a comprehensive review of any form in accord with the requirements in Insurance Code Chapter 1111A.

(n) Request for hearing. The life settlement broker or provider may make a written request for a hearing to the Texas Department of Insurance, Chief Clerk, MC-GC-CCO, P.O. Box 12030, Austin, Texas 78711-2030, on receiving notification under subsection (l) of this section of any withdrawal of approval or disapproval of a form by the department.

(o) Filing fees. Applicable fees for filings made pursuant to this division are set forth in paragraphs (1) - (4) of this subsection.

(1) For filing a complete life settlement contract, including forms related to the life settlement contract, a fee of $100.

(2) For filing life settlement contract forms individually, a fee of $100 for each filing.

(3) For filing a resubmission of a previously disapproved life settlement contract form, a fee of $50.

(4) For each refiling of a previously withdrawn life settlement contact form, a fee of $50.

§3.1742. Shopper's Guide.

The commissioner adopts by reference the form Important Information You Should Know Before Entering Into A Life Settlement (revised April 2013), as a shopper's guide for delivery to owners during the solicitation process. The life settlement broker, or the

provider if the transaction does not have a broker, must deliver the guide to the owner prior to the execution of the life settlement contract. The form is available from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department's website at www.tdi.texas.gov/forms. The delivery of the shopper's guide satisfies only the requirements of Insurance Code §1111A.012(10) and this section.

SUBCHAPTER R. LIFE SETTLEMENT
DIVISION 4. ANNUAL REPORTING
28 TAC §3.1760

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter R, Division 4, under Insurance Code §1111A.015 and §36.001.

Insurance Code §1111A.015 authorizes the Commissioner to adopt rules to implement Chapter 1111A and regulate the activities and relationships of providers, brokers, insurers, and their authorized representatives.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.1760. Reporting Requirements.

(a) General reporting requirements applicable to all life settlement providers. All life settlement providers must comply with the general reporting requirements set forth in paragraphs (1) and (2) of this subsection.

(1) On or after January 1 and before March 1 of each year, each life settlement provider must submit electronically via email in Excel format to lifehealth@tdi.texas.gov, for the previous calendar year, the life settlement provider data

report form that is adopted by reference in this section, whether or not the provider conducted any transactions during the reporting period.

(2) In complying with the requirements of this section, a life settlement provider may not include any confidential information in the report or in any other way compromise the anonymity of any owner, owner's family members, or owner's spouse.

(b) Report requirements. The commissioner adopts by reference the Life Settlement Provider Data Report form (revised March 2013), to be filed pursuant to subsection (a) of this section. The form is available from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department's website at www.tdi.texas.gov/forms. The report must include the following:

(1) the name and license number of the submitting life settlement provider;

(2) a designated contact person for the report, including the individual's name, address, phone number, fax number, and email address; and

(3) with respect to life settlement contracts executed in Texas for which the insured is a resident of Texas during the reporting period for a policy settled not later than the fifth anniversary of the issue date of policy, as follows:

(A) the total number of life settlement contracts entered into during the immediately preceding calendar year, with the information categorized by policy issue year;

(B) the aggregate face amount of the policies settled during the immediately preceding calendar year, with the information categorized by policy issue year;

(C) the proceeds of life settlement contracts entered into during the immediately preceding calendar year, with the information categorized by policy issue year for policies issued in each of the last five years;

(D) the full name of each insurance company whose policies have been settled and the brokers that settled the policies; and

(E) the name and life settlement broker license number of any persons who estimated life expectancies for a life settlement contract.

(c) Disciplinary action. A life settlement provider that fails or refuses to submit any information required by this section is subject to disciplinary action under Insurance Code §1111A.006 in addition to any other applicable penalty.

(d) 2011 and 2012 data. Notwithstanding the requirements of subsection (a) of this section, each life settlement provider must submit a report with the information required in this section within 60 days from the effective date of this rule for data regarding life settlement contracts entered during the period of January 1, 2011, to December 31, 2011, and January 1, 2012, to December 31, 2012, in Texas, for which the insured is a resident of Texas. A life settlement provider that has already provided complete information required in subsection (b)(3)(A) - (D) of this section by the effective date of this section meets the requirements of this subsection.

SUBCHAPTER S. MINIMUM STANDARDS AND BENEFITS AND READABILITY FOR INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES
28 TAC §§3.3001, 3.3009, 3.3010, 3.3038, 3.3039, 3.3052, 3.3057, 3.3070, 3.3092, 3.3100, 3.3101, and 3.3110

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter S under Insurance Code §§1201.006, 1202.051, and 36.001.

Insurance Code §1201.006 authorizes the Commissioner to adopt reasonable rules as necessary to implement the purposes and provisions of Chapter 1201.

Insurance Code §1202.051 provides that the Commissioner adopt rules necessary to implement §1202.051 and meet the minimum requirements of federal law, including regulations.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3001. Applicability and Scope.

(a) Unless otherwise specified, this subchapter applies to all individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental service associations, delivered, issued for delivery, or renewed in this state on and after the effective date of this section, except they do not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group insurance; individual policies issued pursuant to a conversion privilege under an individual policy delivered or issued for delivery in this state prior to January 1, 1978; policies issued to employees or members as additions to franchise plans in existence on January 26, 1977; or credit accident and sickness insurance policies written under Insurance Code Chapter 1153. Individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental service associations, delivered, issued for delivery, or renewed in this state prior to the effective date of this section are subject to the regulations in effect at the time the policy or contract was delivered, issued for delivery, or renewed.

(b) The requirements contained in this subchapter are in addition to any other applicable regulations previously adopted; however, this subchapter governs wherein any conflict or difference exists. The provisions of applicable statutes govern where ambiguity or difference exists between this subchapter and such statutes.

§3.3009. Policy Definitions of Sickness.

Except as provided in this subchapter, the definition of "sickness" may not be more restrictive than the following: Sickness means illness or disease of an insured person which first manifested itself after the effective date of insurance and while the insurance is in force. A definition of sickness which anticipates the exclusion of coverage of pre-existing conditions subject to the limitations expressed in Insurance Code §1201.208 may not use the phrase "the cause of which originates" or any similar phrase. The definition may be modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability, or similar statute.

§3.3010. Policy Definition of Physician.

This term may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept to the extent of its obligation under the contract all providers of medical care and treatment when such services are within the scope of the providers' licensed authority and are provided pursuant to applicable laws. This definition may not be construed so as to be in conflict with Insurance Code §1451.001.

§3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions.

(a) Except as provided by subsection (c) of this section, all individual hospital, medical or surgical coverage (as defined in §3.3002(b)(12) of this title (relating to Definitions)) must be renewed or continued in force at the option of the insured.

(b) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of individual hospital, medical or surgical coverage; however, such coverage sold to an insured before the insured attains Medicare eligibility may contain a clause that excludes payments for benefits under the policy to the extent that Medicare pays for such benefits.

(c) Individual hospital, medical or surgical coverage may only be discontinued or nonrenewed based on one or more of the following circumstances:

(1) the policyholder has failed to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(2) the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy;

(3) the insurer is ceasing to offer individual hospital, medical or surgical coverage under the particular type of policy, or is ceasing to offer any form of individual hospital, medical or surgical coverage in this state, in accordance with subsections (d) and (e) of this section;

(4) in regards only to coverage offered by an issuer under Insurance Code Chapter 842, the insured no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health-status-related factor of covered individuals.

(d) An insurer may elect to discontinue offering a particular type of individual hospital, medical or surgical coverage plan in the individual market only if the insurer:

(1) provides written notice to each covered individual of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage;

(2) offers to each covered individual on a guaranteed issue basis the option to purchase any other individual hospital, medical or surgical insurance coverage offered by the insurer at the time of the discontinuation; and

(3) acts uniformly without regard to any health-status related factors of a covered individual or dependents of a covered individual who may become eligible for the coverage.

(e) An insurer may elect to refuse to renew all individual hospital, medical or surgical coverage plans delivered or issued for delivery by the insurer in this state only if the insurer:

(1) notifies the commissioner of the election not later than the 180th day before the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;

(2) notifies each affected covered individual not later than the 180th day before the date on which coverage terminates for that individual; and

(3) acts uniformly without regard to any health-status related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) An insurer that elects not to renew all individual hospital, medical or surgical coverage in Texas in accordance with subsection (e) of this section may not issue any such coverage in Texas during the five-year period beginning on the date of discontinuation of the last such coverage not renewed.

(g) Nothing in this section prohibits or restricts an insurer's ability to make changes in premium rates by classes in accordance with applicable laws and regulations.

(h) Nothing in this section may be interpreted as prohibiting an insurer from making policy modifications mandated by state law, or, acting consistently with §3.3040(b) of this title (relating to Prohibited Policy Provisions), from honoring requests from a policyholder for modifications to an individual policy or offering policy modifications uniformly to all insureds under a particular policy form.

§3.3039. Other Mandatory Policy Provisions.

(a) Each individual policy of accident and sickness insurance, including a policy issued by a company subject to Insurance Code Chapter 842, that is delivered, issued for

delivery, or renewed in Texas on or after January 1, 1988, must contain a benefit provision which states, "All benefits payable under this policy on behalf of a dependent child insured by this policy for which benefits for financial and medical assistance are being provided by the Texas Health and Human Services Commission will be paid to the Texas Health and Human Services Commission" whenever:

(1) the Texas Health and Human Services Commission is paying benefits under Human Resources Code Chapter 31 or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code; and

(2) the parent who purchased the individual policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support.

(b) The insurer or group nonprofit hospital service company must receive at its home office, written notice affixed to the insurance claim when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to the Texas Health and Human Services Commission.

(c) With respect to any policy forms approved by the Texas Department of Insurance prior to January 1, 1988, an insurer is authorized to achieve compliance with this section by the use of endorsements or riders, provided such endorsements or riders are approved by the Texas Department of Insurance as being in compliance with this section and the provisions of the Insurance Code.

§3.3052. Standards for Termination of Insurance Provision.

(a) A policy subject to this subchapter must include termination provisions that specify as to each eligible family member, as set out in §3.3051 of this title (relating to Initial and Subsequent Conditions of Eligibility Provision), the age, or event, if any, upon which coverage under the policy will terminate.

(b) In regard to individual hospital, medical or surgical coverage, a policy may only contain the following bases for termination of coverage:

(1) the bases for nonrenewal contained in §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions);

(2) in regard to policies covering a spouse of the primary insured or dependents:

(A) Coverage of the spouse may terminate upon the dissolution of the marriage through divorce or other lawful means, subject to this section, §21.407 of this title (relating to Continuance of Coverage) and other applicable law; and

(B) Coverage of a dependent may terminate upon the dependent's attainment of a limiting age, subject to Insurance Code §1201.059, this section, and other applicable law.

(c) A policy containing noncancellable, guaranteed renewable or limited guarantee of renewability provisions may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The provision must stipulate that in the event of the insured's death the spouse of the insured, if covered under the policy, will become the insured.

(d) The provision must stipulate that if the insurer accepts premium for coverage extending beyond the date, age, or event specified for termination as to an insured family member, then coverage as to such person will continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age outlined in Insurance Code §1201.011.

(e) In the event of cancellation by the insurer or refusal to renew by the insurer of a policy providing pregnancy benefits, the provision must 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 continued in force.

(f) The provision must stipulate that termination of the policy by the insurer will be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured person limited to the duration of the policy benefit period, payment of the maximum benefits or to a time period of not less than three months.

(g) The provision may provide for the termination or suspension of family members who become eligible for coverage provided by the federal government.

(h) A policy may not provide for termination of coverage of a dependent child on attainment of the limiting age for dependent children specified in the policy while the child is:

(1) incapable of self-sustaining employment due to mental retardation or physical handicap; and

(2) chiefly dependent upon the insured for support and maintenance. Proof of the incapacity and dependency must be furnished to the insurer by the insured within 31 days of the child's attainment of the limiting age and subsequently as may be required but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Upon the attainment of the limiting age, the applicable adult premium may be charged.

§3.3057. Standards for Exceptions, Exclusions, and Reductions Provision.

(a) An exception or exclusion is any provision in a policy whereby coverage for a specified hazard in entirely eliminated. It is a statement of a risk not assumed under the terms and provisions of the contract. Extensive listing of diseases to be excluded will not

be acceptable unless the insurer can show that such are necessary and proper to the coverage provided.

(b) A reduction is a provision which takes away some portion, but not all of the coverage of the policy under certain specific conditions. Such relates to a risk assumed by the insurer but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction clause not been used.

(c) Exceptions, exclusions, and reductions must be clearly expressed as a part of the benefit provision to which such applies or, if applicable to more than one benefit provision, must be set forth as a separate provision and appropriately captioned. Policies containing the specified exclusionary subjects appearing in Exhibit A will be acceptable; however, this may not preclude the consideration or approval of other exceptions or exclusions if such are deemed reasonable and appropriate to the risk undertaken and are approved by the commissioner. Exhibit A is adopted herein by reference. Copies of Exhibit A may be obtained by contacting the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department's website at www.tdi.texas.gov/forms.

(d) The acceptable exclusions set forth in Exhibit A may not impair or limit the use of waivers to exclude, limit, or reduce coverage or benefits for named or specifically described pre-existing disease, physical condition, or extra hazardous activity. If waivers are required as a condition of issuance, renewal, or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

(e) If a policy contains a military service exclusion or a provision suspending coverage during military service, and if the premiums are either reduced or refunded for the period of such military service, such must be clearly stated in the policy.

(1) As to coverage that is not noncancellable, subject to limited renewability at option of the insured or subject to a limited guarantee of renewability:

(A) if the policy contains a "status" type of exclusion which excludes all coverages applicable to an insured person while in military service on full-time active duty, the policy must provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis;

(B) if the policy contains a "causation" type exclusion (loss resulting from military service) while an insured person is on full-time active duty in the military, refund of premium is not required since the policy would be operative as to any other loss not resulting from military service causes;

(C) if a policy contains a provision for voluntary suspension of coverage during military service and an identifiable premium is charged for such coverage upon written request for suspension, a pro rata premium must be refunded.

(2) As to coverage that is noncancellable, subject to limited renewability at option of the insured or a limited guarantee of renewability:

(A) the policy may provide for refund of the entire premium for the period of military service or for a partial refund of the premium from the date the insurer receives notice and it may adjust any such refund for any change in reserves during the period of suspension;

(B) the policy may contain a military service exclusion or a provision for suspension of coverage upon entry into military service with the right of reinstatement upon termination of such service without evidence of insurability, if applied for within a specified period of not less than 60 days;

(C) the insurer may charge a partial premium during the period of suspension which will anticipate accumulation of reserves required by law or regulation and related cost factors.

§3.3070. Minimum Standards for Benefits Generally.

The following minimum standards for benefits are prescribed for the categories noted in §§3.3071 - 3.3077 and §3.3079 of this title (relating to Minimum Standards and Benefits and Readability for Accident and Health Insurance Policies). No individual policy of accident and sickness insurance, or a subscriber contract of a hospital, medical, or dental services corporation, may be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories except as otherwise provided by law or this subchapter. Such policies must also meet the requirements of Insurance Code Chapter 1701. Nothing in this section will preclude the issuance of any policy or contract combining two or more of the categories of coverage as set forth in Insurance Code §1201.104.

§3.3092. Format, Content, and Readability for Outline of Coverage.

(a) Format.

(1) Each outline of coverage must contain the appropriate text and be in the appropriate format of the outlines of coverage set forth in this subchapter and may not contain any material of an advertising nature, except for the insurer's logotype.

(2) The outline of coverage must be plainly printed in light-faced type of a style in general use, the size of which must be uniform except as provided in paragraph (4) of this subsection and not less than 12 point with a lowercase unspaced alphabet length not less than 130 point, with a minimum of one-point leading.

(3) The contrast and legibility of the color of ink and the color of paper of the outline of coverage must be substantially the equivalent of that of black ink on white paper.

(4) Text that is capitalized or underscored in the outline of coverage may be of a different style type the size of which may be the same as or larger than that of other text.

(5) When an outline of coverage is integrated with a sales brochure, multi-colored ink may be used on all portions of the brochure except the outline of coverage.

(b) Content.

(1) Drafting instructions for paragraph 1. The following language must appear in each outline of coverage: READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Drafting instructions for paragraph 2. This paragraph must be in the applicable form set out in §3.3093 of this title (relating to Prescribed Outlines of Coverage) for the category of coverage provided.

(3) Drafting instructions for paragraph 3. This paragraph must set forth a brief specific description of the benefits (including dollar amounts and number of days duration where applicable) provided by the policy with which the outline of coverage is to be used. The description must be stated clearly and concisely, and include a description of any elimination periods, deductible amounts, inner limits or co-payment requirements, and any other items applicable to the benefits described. If a benefit is stated in the outline of coverage but not provided in the policy as applied for or issued, a notation must be made in the outline of coverage to the effect that no coverage is provided for that benefit.

(4) Drafting instructions for paragraph 4. This paragraph must briefly describe any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in paragraph (3)

of this subsection. The circumstances under which any reduction becomes operative must be included. Limitations on coverage for pre-existing conditions that qualify payment of benefits must be summarized. Provisions which reduce benefits otherwise payable due to other coverage must be described.

(5) Drafting instructions for paragraph 5. This paragraph must include a description of the provisions regarding renewability including any limitation by age, time, or event, status requirements, any reservation by the insurer of a right to change premiums or right of cancellation, and any other matter appropriate to the terms and conditions of renewability. If the policy, or any part of the policy, consists of individual hospital, medical, or surgical coverage, paragraph 5 must include language regarding guaranteed renewability substantially similar to the following: "This (policy/coverage) is guaranteed renewable. That means that you have the right to keep the policy in force with the same benefits, except that we may discontinue or terminate the policy if: 1. You fail to pay premiums as required under the policy; 2. You have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy; or 3. We stop issuing the (policy/coverage) in Texas, but only if we notify you in advance." (Include, if coverage offered by an issuer under the Insurance Code, Chapter 842: "4. You no longer reside, live, or work in our service area, as described in the policy.") (Include, if applicable: "This policy will not terminate when a covered person becomes eligible for Medicare. However, the policy excludes any benefits that are paid to a covered person by Medicare.") "Unless the policy is 'noncancellable,' as defined in the policy, we have the right to raise rates on your policy at each time of renewal, in a manner consistent with the policy and Texas law. If the policy is noncancellable, our right to raise rates is limited by the definition of 'noncancellable' contained in the policy, and by Texas law."

(6) Drafting instructions for paragraph 6. The total premium payable must be stated. In the event the mode stated is not an exact multiple of the annual premium, then the annual premium must also be stated. Initial policy fees must be stated separately. If premiums are "step-rated," they must either be disclosed for each step or the initial premium may be disclosed accompanied by a statement as follows: "Renewal premiums for this policy will increase periodically depending upon (your age) (the policy year)." Unless a policy is issued with guaranteed premium rates, this paragraph must contain the statement "premiums are subject to change." This paragraph must also include a statement of the policy grace period.

(c) Readability.

(1) Insurers must utilize an appropriate test of readability in gauging the readability of paragraphs 3 through 6 of the Outline of Coverage prescribed in this section and §§3.3090, 3.3091, and 3.3093 of this title (relating to Outline of Coverage Generally; Notice Requirements for Outline of Coverage of Limited Benefit, Supplemental and Non-conventional Coverages; and Prescribed Outlines of Coverage). Such test may be selected from any one of the following:

(A) "Flesch" Formula, Rudolf Flesch, *The Art of Readable Writing* (1949, as revised in 1974);

(B) Fry Graph, Edward Fry, *Journal of Reading* (April 1968);

(C) Chall Readability, Jean Chall and Edgar Dale, "A Formula for Predicting Readability"; *Educational Research Bulletin* (January 1948);

(D) FOG Index, Robert Gunning, "The Technique of Clear Writing" and "How to Take the Fog Out of Writing," Dartnell Press;

(E) Farr-Jenkins-Paterson, "Simplification of Flesch Reading Ease Formula," *Journal of Applied Psychology* (October 1951);

(F) any other test which may from time to time be established or approved by the commissioner.

(2) In utilizing a readability test, insurers must establish a specific minimum level of readability which may not be more difficult than the equivalent of a ninth-grade reading level. In determining the readability level, all prescribed language, any medical terms, or formal names may be deleted as a criteria of readability.

(3) Each insurer must notify the commissioner as to the readability test adopted in compliance with this section and any changes made or intended to be made in the use of such text.

(4) The insurer must file the readability score of the outline of coverage along with the outline of coverage.

(5) This subsection does not apply to outlines of coverage used in connection with policies providing business buy out agreements or key man coverage.

§3.3100. Policy Readability Generally.

(a) In order to increase policyholder understanding of individual accident and sickness policies, insurers are encouraged to draft individual accident and sickness policies in a readable manner. In order not to devalue the policy as a legal document the utmost care and caution must be used in its preparation. Insurance Code Chapter 1201, Subchapter E, requires the use of certain policy provisions in particular language or provisions not less favorable to the insured or beneficiary than those set forth in said subchapter. The same is true with respect to optional policy provisions as provided in Insurance Code §§1201.219 - 1201.226. Notwithstanding these requirements of law, insurers are urged to experiment with new language in these areas.

(b) Insurers are encouraged to follow the principles set forth in §3.3101 of this title (relating to Organization of Policy Format for Readability) and §3.3102 of this title (relating to Language Readability) when preparing individual accident and sickness policies.

§3.3101. Organization of Policy Format for Readability.

(a) The text of the policy must be organized so that it follows a logical sequence.

(b) Coverages must be self-contained and independent.

(c) The use of provisions which refer the reader to another section must be avoided to the extent possible.

(d) General policy provisions applying to all or several like coverages, such as defined words and terms, must be located in a common area.

(e) Insurers may utilize a separate definition section for words used throughout the policy. If a separate definition section is used, it must appear early in the policy format.

(f) Nonessential provisions must be eliminated.

(g) Captions must be of type size and style to clearly stand out.

(h) Type size and style must be legible and comply with the requirements set forth in Insurance Code §1201.054.

(i) Ample blank space must separate the policy provisions.

(j) Ample blank space must appear between the columns of printing and the border of the paper.

(k) A table of contents or index may be utilized to enable the policyholder to readily locate particular provisions.

§3.3110. Effective Date; Applicability of Certain Provisions to Policies Deemed Continuous under Insurance Code.

(a) The sections of this subchapter, as amended and adopted by the commissioner, will be effective 20 days from the date they are filed with the Office of the Secretary of State and be applicable to all individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental service associations delivered, issued for delivery, or renewed on and after such date. Individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental service associations, delivered, issued for delivery, or renewed in this state prior to the effective date of this section are subject to the regulations in effect at the time the policy or contract was delivered, issued for delivery, or renewed.

(b) In regard to policies issued before December 22, 1997, and deemed continuous and not annually renewed pursuant to Insurance Code §1202.001:

(1) Such policies will be considered "renewed" for the purposes of complying with the mandatory guaranteed renewability provisions of this subchapter, if applicable to the coverage offered in such policies, as set forth in §3.3020 of this title (relating to Policy Definition of Guaranteed Renewable and Limited Guarantee of Renewability) and §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions), on the first policy anniversary date after December 22, 1997.

(2) Such policies will not be subject to any other provisions of this subchapter, unless the statutory period of continuity prescribed by Insurance Code §1202.001 ends, and the policy is then renewed. During such period of continuity, the policies will continue to be subject to applicable rules as they existed prior to December 22, 1997.

SUBCHAPTER T. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES
28 TAC §3.3321

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter T under Insurance Code §1652.005 and §36.001.

Insurance Code §1652.005 provides that the Commissioner adopt rules necessary and proper to carry out Chapter 1652.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3321. Reporting of Multiple Policies.

(a) On or before March 1 of every year, every issuer of Medicare supplement coverage in this state must report the following information to the Texas Department of Insurance for every individual resident of this state for whom the insurer or entity has more than one Medicare supplement policy or certificate in force:

(1) policy and/or certificate number; and

(2) date of issuance.

(b) The items set forth in subsection (a) of this section must be grouped by individual policyholder and reported on a form substantially similar in layout, design, and wording to the form entitled "Form for Reporting Multiple Medicare Supplement Insurance Policies," which the Texas Department of Insurance adopts and incorporates herein by reference. Copies of this form are available from and on file at the office of the Consumer Protection and Services Program and reports of multiple Medicare supplement policies should be made to the Texas Department of Insurance, Consumer Protection and Services, MC-CO-CPS, P.O. Box 12030, Austin, Texas 78711-2030.

SUBCHAPTER U. NEWBORN CHILDREN COVERAGE
28 TAC §§3.3401 - 3.3403

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter U under Insurance Code §1367.055 and §36.001.

Insurance Code §1367.055 provides that the Commissioner may adopt rules necessary to implement Chapter 1367, Subchapter B.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3401. Purpose.

The purpose of this subchapter is implementation of Insurance Code §1367.003, so as to clarify the applicability of §1367.003 to insurance policies to be issued in the future and to existing policies.

§3.3402. Applicability and Scope.

This subchapter applies to all individual or group policies of accident and sickness insurance (including policies issued by companies subject to Insurance Code Chapter 842, as amended) delivered or issued for delivery to any person in this state which provides for either accident and sickness coverage of additional newborn children or for maternity benefits.

§3.3403. General Rules of Application.

(a) No individual policy or group policy of accident and sickness insurance which provides for accident and sickness coverage of additional newborn children may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn

infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

(b) No individual policy or group policy of accident and sickness insurance which provides for maternity benefits may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

(c) If the policy provides accident and sickness coverage for newborn children, such coverage must be at least as comprehensive as the coverage provided under the policy for other children for loss as a result of an accident or sickness.

(d) If the policy provides maternity benefits, and included in such benefits are coverages for newborn infants, such policy may not contain any provision excluding or limiting initial coverage of newborn infants for a period of time, or limit or exclude coverage for congenital defects of a newborn child.

(e) The initial coverage provided newborn children must continue for a period of at least 31 days. The insurer may require that before the coverage continues beyond this initial 31-day period, the policyholder must notify the insurer of the birth of the newborn child and pay any additional premium required to maintain the coverage in force. Any additional premium required for the initial period of coverage may be charged.

(f) Insurance Code §1367.003 applies to all accident and sickness policies issued or issued for delivery, renewed, extended, or amended in the State of Texas on and after January 1, 1974. The insurer, upon a renewal, extension, or amendment, may charge such additional premiums as are just and reasonable for the additional risk incurred by compliance with Insurance Code §1367.003. With respect to any policy forms approved by the Texas Department of Insurance prior to the effective date of §1367.003, an insurer is authorized to achieve compliance with §1367.003 by the use of endorsements or riders provided such endorsements or riders are approved by the Texas Department of

Insurance as being in compliance with Insurance Code §1367.003 and other provisions of the Texas Insurance Code.

(g) Insurance Code §1367.003 applies to policies written before January 1, 1974, if and when such a policy is "renewed, extended or amended" after January 1, 1974. If the provisions of a policy written before January 1, 1974, allow the insurer to renegotiate the terms of the policy after January 1, 1974, or allow the insurer to adjust the premiums charged under the policy after January 1, 1974, and if at the time such renegotiation or adjustment could be accomplished and is accomplished, the policy continues in force or a policy with substantially similar coverage is agreed to by the insured and insurer, then the policy will be said to have been "renewed, extended or amended" for purposes of Insurance Code §1367.003, and the requirements of §1367.003 will attach to the policy.

(h) Insurance Code §1367.003 applies to any policy except a "non-cancellable and guaranteed renewable" policy written before January 1, 1974, if such policy is "renewed, extended or amended" or a rate adjustment could be made after January 1, 1974. If a group policy is written in conjunction with a collective bargaining agreement, such policy will be considered "renewed, extended or amended" upon the expiration of any applicable collective bargaining agreement.

(i) Nothing in this subchapter will be deemed to extend the provisions of Insurance Code §1367.003 to insurance contracts providing benefits only for specified diseases, pure accident policies, disability only policies, or loss of time only policies.

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE, NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES AND ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY

DIVISION 2. NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE

28 TAC §§3.3829, 3.3832, 3.3837, 3.3842, and 3.3849

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter Y, Division 2, under Insurance Code §§1651.004, 1651.107, and 36.001.

Insurance Code §1651.004 authorizes TDI to adopt reasonable rules necessary and proper to carry out Chapter 1651.

Insurance Code §1651.107 provides that the Commissioner may adopt rules as necessary to implement Chapter 1651, Subchapter C.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3829. Required Disclosures.

(a) Required disclosure of policy provisions.

(1) Long-term care insurance policies and certificates must contain a renewability provision as required by §3.3822 of this title (relating to Minimum Standard for Renewability of Long-term Care Coverage). Such provision must be appropriately captioned, appear on the first page of the policy, and clearly state the duration, where limited, of renewability and the duration of the coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder under a long-term care insurance policy and/or certificate, all riders or endorsements added to a long-term care insurance policy and/or certificate after the date of issue or at reinstatement or renewal, which reduce or eliminate benefits or coverage in the policy and/or certificate, require a signed acceptance by the policyholder. 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 policyholder, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits in connection with riders or endorsements, such premium charge must be set forth in the policy, certificate, rider, or endorsement.

(3) A long-term care insurance policy and certificate which provides for the payment of benefits on standards described as usual and customary, reasonable and customary, or words of similar import, must include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Insurance Code Chapter 1651 or §3.3824 of this title (relating to Preexisting Conditions Provisions) must set forth a description of such limitations or conditions in a separate paragraph of the policy or certificate and label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates must appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates must contain a claim denial provision which is appropriately captioned. Such provision must clearly state that if a claim is denied, the insurer will make available all information directly relating to such denial within 60 days of the date of a written request by the policyholder or certificate holder, unless such disclosure is prohibited under state or federal law.

(9) A long-term care insurance policy and certificate which includes benefit provisions under §3.3818(b) of this title (relating to Standards for Eligibility for Benefits) must disclose, within a common location and in equal prominence, a description of all benefit levels payable for the coverage described in §3.3818(b) of this subchapter. Criteria utilized to determine eligibility for benefits must be disclosed in all long-term care insurance policies and certificates, in the manner prescribed by §3.3818 of this subchapter.

(10) If the insurer intends for a long-term care insurance policy or certificate to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate must include disclosure language substantially similar to the following: "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b)."

(11) If the insurer does not intend for the policy to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate must include disclosure language substantially similar to the following: "This policy is not intended to be a qualified long-term care insurance contract. This long-term care insurance policy does not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B."

(12) A long-term care policy or certificate which provides for increases in rates must include a provision disclosing that notice of an upcoming premium rate

increase will be provided no later than the 45th day preceding the date of the implementation of the rate increase.

(b) Required disclosure of rating practices.

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices set forth in paragraph (2) of this subsection apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection will apply on the policy anniversary following January 1, 2003.

(2) Insurers must provide the following information as set forth in this paragraph and Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate:

(A) a statement that the policy may be subject to rate increases in the future;

(B) an explanation of potential future premium rate revisions, including an explanation of contingent nonforfeiture benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(C) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(D) a general explanation for applying premium rate or rate schedule adjustments that includes:

(i) a description of when premium rate or rate schedule adjustments will become effective (e.g., next anniversary date, next billing date, etc.); and

(ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this paragraph if the premium rate or rate schedule is changed;

(E) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

(i) the policy forms for which premium rates have been increased;

(ii) the calendar years when the form was available for purchase; and

(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 also may be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(3) Subsequent to the information required by paragraph (2) of this subsection, insurers may, in a manner that is not misleading, provide in addition to the information required in paragraph (2)(E) of this subsection, explanatory information related to the rate increases.

(4) Insurers may exclude from the disclosure required by paragraph (2)(E) of this subsection 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 the acquisition.

(5) If an acquiring insurer files for a rate increase either on a long-term care policy form acquired from a nonaffiliated insurer, or on a block of policy forms acquired from a nonaffiliated insurer on or before January 1, 2002, or the end of the 24-month period after the date of the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer must include the disclosure of that rate increase in accordance with paragraph (2)(E) of this subsection.

(6) If the acquiring insurer in paragraph (5) of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer referenced in paragraph (5) of this subsection, the acquiring insurer must make all disclosures required by paragraphs (2)(E), (3), (4), and (5) of this subsection.

(7) An applicant must sign an acknowledgement at the time of application that the insurer has made the disclosure(s) required under paragraph (2) of this subsection. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant must sign no later than at the time of delivery of the policy or certificate.

(8) An insurer must use the text for Form Number LHL560(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) to comply with the requirements in paragraph (2)(A) and (E) of this subsection and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(I) to comply with the requirements in paragraph (2)(B), (C), and (D) of this subsection. The effective dates for use of each form are specified in subsection (c) of this section. The following requirements and procedures apply to Form Number LHL560(LTC) and Form Number LHL561(LTC):

(A) The text in each form must be in at least 12-point type and must follow the order of the information presented in the form.

(B) The text and order of presentation of information in each form are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) if the insurer files the forms for review and approval by the commissioner as provided in subparagraphs (C) and (F) of this paragraph.

(C) Any form filed pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(D) An insurer may add a company name and identifying form number to Form Number LHL560(LTC) and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) without obtaining commissioner approval.

(E) The Instructions to Company that are included in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) are to aid the insurer in drafting the forms and should not be included in the text of the forms used by the insurer.

(F) The forms filed pursuant to subparagraph (B) of this paragraph should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(G) Persons may obtain the required form by making a request to the Texas Department of Insurance, Life and Health Division, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department's website at www.tdi.texas.gov/forms.

(H) A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is as follows:

Figure: 28 TAC §3.3829(b)(8)(H)

Long-Term Care Insurance
Personal Worksheet

FOR THE STATE OF TEXAS

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for careor don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers ____________________

The premium for the coverage you are considering will be [$ _____ per month, or $__ per year,] [a one-time single premium of $________.]

Type of Policy (noncancellable/guaranteed renewable): ____________

The Company's Right to Increase Premiums: ____________________

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.]

Instructions To Company: Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History
We have sold long-term care insurance since [year] and have sold this [policy/rider], Form No.[_] since (year). [We have never raised rates for any long-term care (policy/rider) sold in this state or any other state.] [We have not raised rates for this (policy/rider) or a similar (policy/rider) in this state or any other state in the last ten years.] [We have raised

rates on this (policy/rider) or a similar (policy/rider) in thelast ten years. Following is a summary of the rate increases:]

Instructions To Compan*y*: A company may use the first bracketed sentence above only if it has never increased rates under any prior individual or group policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar individual or group policy forms in this state or any other state during the last 10 years. The list shall specify the individual or group policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics.The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

• From my Income • From my Savings/Investments • My Family will Pay

• Have you considered whether you could afford to keep this policy if the premiums went up, for example by 20%?]

***Instructions To Company*:** The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

• Under $10,000 • $[10-20,000] • $[20-30,000] • $[30-50,000] • Over $50,000

Instructions to Company: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

• No change • Increase • Decrease

If you will be paying premiums with money received only from your own income,a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) • Yes • No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

• From my Income • From my Savings/Investments • My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annualcost would be about [insert $ amount] if costs increase 5% annually.

***Instructions to Company*:** The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days_______ Approximate cost $________for that period of care.

How are you planning to pay for your care during the elimination period? (check

one)

• From my Income • From my Savings/Investments • My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

• Under $20,000 • $20,000-$30,000 • $30,000-$50,000 • Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

• No change • Increase • Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Questions Related to Your Needs

You must be diagnosed with cognitive impairment or be unable to perform two (2) of thefollowing six (6) activities of daily living (ADLs) – bathing, continence, dressing, eating, toileting, and transferring – prior to your long-term care benefits being triggered. Do you understand this policy limitation**?** • **YES** • **NO**

What type of long-term care service do you anticipate utilizing? (check all that apply)

• Nursing home care • Assisted living care • Home health care
• Adult day care • Hospice care • Respite care • other services

Disclosure Statement

☐	The answers to the questions above describe my financial situation.OR I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this formwith me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** ***Instructions to Company**:* This box must be checked.

Signed: ____ ________________________
(Applicant) (Date)

[• I explained to the applicant the importance of completing this information.

Signed: ____ ________________________
(Agent) (Date)

Agent's Printed Name:____]

[In order for us to process your application, please return this signed statement to [nameof company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: ____ ________________________]
(Applicant) (Date)

***Instructions to Company*:** Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

***Instructions to Company*:** When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the pagemay be removed.

Form Number LHL560(LTC)

(I) A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is as follows:

Figure: 28 TAC §3.3829(b)(8)(I)

Instructions to Company: This form provides information to the applicant regarding premium rate schedules, rateschedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

FOR THE STATE OF TEXAS

Long-Term Care Insurance Potential Rate Increase Disclosure Form
(Company Name, address & phone number)

1. (Premium rate/Premium rate schedules) that (is/are) applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase (is/are) ($_________) shown on the application. The (premium/premium rate schedule) for this coverage will be (shown on the schedule page of/attached to) your (policy/rider).

2. If your rates are changed, the new rates will become effective on the (next anniversary date/next billing date, etc.). The new rates will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised (premium rate/premium rate schedule) if the (premium/premium rate schedule) is changed.

3. This long-term care coverage is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to (your increasing age or) declining health, but your rates may go up based on the experience of all insureds with a (policy/rider) similar to yours.

4. If you receive a (premium rate/premium rate schedule) increase in the future, youwill be notified of the new premium amount and you will be able to exercise at least one of the following options:

   (a) Pay the increased premium and continue your coverage in force as is.

   (b) Reduce your coverage benefits to a level such that your premiums will not increase.

   (c) Exercise your long-term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.

(d) Exercise your contingent nonforfeiture rights - See No. 5. This option isavailable if you do not purchase a long-term care nonforfeiture option mentioned in (c) above.

5. Contingent Nonforfeiture Rights

If the premium rate for your (policy/rider) goes up in the future and you do not buy a long-term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

(a) You will keep some long-term care insurance coverage, if:

(1) Your premium after the increase exceeds your original premiumby the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay your premium within 120 days of the increasecausing your (policy/rider) to lapse.

(b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your (policy/rider) was first issued. If you have already received benefits under the (policy/rider), so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

(c) Except for this reduced lifetime maximum benefit amount, all other (policy/rider) benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your (policy/rider), with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the (policy/rider) at age 65 and paid the $1,000 annualpremium for ten years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to not pay anymore premiums causing your (policy/rider) to lapse.

- Your "paid-up" (policy/rider) benefits are $10,000, provided youhave at least $10,000 of benefits remaining under your (policy/rider.)

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

6. Fixed or Limited Premium Payment Period

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies or certificates that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent nonforfeiture benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

(a) The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 - 80	30%
Over 80	10%

(b) You stop paying your premiums within 120 days of when the premium increase took effect; AND

(c) The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

(1) The total lifetime amount of benefits your reduced paid up policy or certificate will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy or certificate becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

(2) The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy or certificate at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy or certificate benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy or certificate.

Form Number LHL561(LTC)

(9) An insurer must provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice must include the information required by paragraph (2)(B), (C), and (D) of this subsection and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) when the rate increase is implemented. The notice must comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

(c) Effective dates for use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form.

(1) In lieu of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H), insurers may use until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs."

(2) In lieu of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I), insurers may use until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form, LTC RATE INCR DISC-01-2002, that is currently being used in Texas. Insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet.

(3) Insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department.

(4) On and after January 1, 2010, all insurers must use Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I) in accordance with all of the requirements specified for these two forms in this section.

§3.3832. Outline of Coverage.

(a) An outline of coverage must be delivered to an applicant for an individual or group long-term care insurance policy or certificate at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. In the case of agent solicitations, the outline of coverage must be delivered prior to the presentation of an application or enrollment form. In the case of direct-response solicitations, the outline of coverage must be delivered in conjunction with any application or enrollment form. The outline of coverage must comply with the following standards and standard format. The contents of the outline of coverage must include the following prescribed text.

(1) The outline of coverage must be a freestanding document, in no smaller than 12-point type.

(2) The outline of coverage must contain no material of an advertising nature.

(3) Text which is capitalized in the standard format outline of coverage must be capitalized. Text which is underscored in the standard format outline of coverage may be emphasized by boldfacing or by other means which provide prominence equivalent to such underscoring.

(4) Use of text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(b) The outline of coverage must be in the following format.

Figure: 28 TAC §3.3832(b)

(Company Name)
(Address-City & State)
(Telephone Number)
Long-Term Care Insurance
Outline of Coverage
(Policy Number or Group Master Policy and Certificate Number)
(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)

(1) POLICY DESIGNATION. This policy is (an individual policy of insurance) (a group policy which was issued in (indicate jurisdiction in which group policy was issued)).

(2) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provision will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both you and your insurance company. It is very important, therefore, that you READ YOUR POLICY OR CERTIFICATE CAREFULLY.

(3) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(A) (Provide a brief description of the right to return--"free look" provisions of the policy. State that the person to whom the policy is issued is permitted to return the policy within 30 days (or more, if so provided for in the policy) of its delivery to that person, and that in the instance of such return the premium will be fully refunded.)

(B) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

(4) MEDICARE SUPPLEMENT INSURANCE DISCLAIMER. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the insurance company.

(A) (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government, or any state government.

(B) (For direct response) (insert company name) is not representing Medicare, the federal government, or any state government.

(5) LONG-TERM CARE COVERAGE. Long-term care insurance is designed to provide coverage for necessary or medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. Coverage is provided for the benefits outlined in paragraph (6) of this subsection. The benefits described in paragraph (6) of this subsection may be limited by the limitations and exclusions in paragraph (7) of this subsection.

(6) BENEFITS PROVIDED BY THIS POLICY.

(A) (Describe covered services and benefits, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(B) (Describe institutional benefits, by skill level.)

(C) (Describe noninstitutional benefits, by skill level.)

(D) Eligibility for Payment of Benefits (NOTE: This portion of the outline of coverage must include an explanation of any instance in which provision of benefits is predicated upon the insured's having met a specific standard of eligibility for that benefit under the terms of the policy. The procedural requirements must be stated for such screening for the provision of benefits. The inability to perform activities of daily living and the impairment of cognitive ability must be used to measure an insured's eligibility for long-term care and must be defined and described as part of the outline of coverage in conformance with the provisions of §3.3804 of this title (relating to Definitions). The outline of coverage also must specify when an attending physician or other specified person must certify that the insured has a certain level of functional dependency in order for the insured to be eligible for benefits. If the policy or certificate contains provisions allowing for additional benefits (such as waiver of premiums, respite care, etc.) upon the occurrence of a certain contingency or contingencies, this paragraph also must delineate each such benefit and specify the criteria for eligibility for each benefit.

(7) LIMITATIONS AND EXCLUSIONS. (State the principal exclusions, reductions, limitations, restrictions, or other qualifications to the payments of benefits contained in the policy, including:

(A) preexisting conditions;

(B) noneligible facilities/providers;

(C) noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(D) exclusions/exceptions; and

(E) limitations.) THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

(8) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:

(A) that the benefit level will not increase over time;

(B) any automatic benefit adjustment provisions;

(C) whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(D) if such a guarantee is present, whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; and

(E) whether any additional premium charge will be imposed, and how that is to be calculated.)

(9) TERMS UNDER WHICH THE (POLICY) (CERTIFICATE) MAY BE CONTINUED IN FORCE AND IS CONTINUED. (For long-term care insurance policies or certificates, describe one of the following permissible policy renewability provisions.)

(A) (Policies and certificates which are guaranteed renewable must contain the following statement:)

(i) RENEWABILITY: THIS POLICY (CERTIFICATE) IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy (certificate), to continue this policy as long as you pay your premiums on time. (Company Name) cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(ii) (Policies and certificates that are noncancellable must contain the following statement:) RENEWABILITY: THIS POLICY (CERTIFICATE) IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. (Company Name) cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, (Company Name) may increase your premium at that time for those additional benefits.

(B) (for group coverage, a specific description of continuation/ conversion provisions applicable to the certificate and group policy); and

(C) (a description of waiver of premium provisions or a statement that there are no such provisions.)

(10) ALZHEIMER'S DISEASE, OTHER ORGANIC BRAIN DISORDERS, AND BIOLOGICALLY BASED BRAIN DISEASES/SERIOUS MENTAL ILLNESS. (State that the policy provides coverage for insureds who meet the eligibility requirements explained above in paragraph 6 of this subsection because of a clinical diagnosis of Alzheimer's disease or related degenerative illnesses and illnesses involving dementia, or due to biologically based brain diseases/serious mental illnesses, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive). Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

(11) PREMIUM.

(A) (State the total annual premium for the policy. In the event the total premium for the policy is different from the annual premium, then the total premium also must be stated. Initial policy fees must be stated separately.)

(B) (If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.)

(C) (This paragraph also must include a statement of the policy grace period.)

(12) TEXAS DEPARTMENT OF INSURANCE'S CONSUMER HELP LINE. An insurer must include notification that the prospective insured may call the Texas Department of Insurance's Consumer Help Line at 1-800-252-3439 for agent, company, and any other insurance information, and 1-800-599-SHOP to order publications related to long-term care coverage, and the Texas Health and Human Services Commission at (1-800-252-9240 or current number if different) to receive counseling regarding the purchase of long-term care or other health care coverage.

(13) DENIAL OF APPLICATION. A long-term care insurer must state that within 30 days of denial of an application, it will refund any premiums paid by a long-term care applicant.

(14) OFFER OF INFLATION PROTECTION. Insurers must include the information set out in subparagraphs (A) and (B) of this paragraph regarding the offer of inflation protection.

(A) A graphic comparison of the benefit levels of a policy and certificate, if applicable, that increases benefits due over the policy interval with a policy that does not increase benefits, depicting benefit levels over at least a 20-year period, must be provided.

(B) A disclosure of any expected premium increases or additional premiums to pay for automatic or optional benefit increases must be made. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer must also disclose the magnitude of the potential

premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.

(15) OFFER OF NONFORFEITURE BENEFITS. Insurers must include the information set out in subparagraphs (A), (B), and (C) of this paragraph regarding the offer of nonforfeiture benefits.

(A) A complete and clear explanation of each nonforfeiture option being offered, including an actual numerical example.

Figure: 28 TAC §3.3832(b)(15)(A)

Example

$1000 Annual Premium

Age	Total Premium Paid (No claims)	Rider Premium	Shortened Benefit $50/day	Shortened Benefit $100/day
50	$10,000	$1,500	200 days	100 days
60	$20,000	$3,000	400 days	200 days
70	$30,000	$4,500	600 days	300 days
80	$40,000	$6,000	800 days	400 days

(B) Disclosure of the premium and percentage increase in premium associated with each of the nonforfeiture benefits offered.

(C) Disclosure that if the nonforfeiture offer is rejected that a contingent benefit upon lapse will be provided and a description of such benefit.

(16) DISCLOSURE REGARDING FEDERAL TAX TREATMENT OF LONG-TERM CARE INSURANCE POLICY.

(A) Policies intended to be qualified long-term care insurance policies. Include disclosure language substantially similar to the following: "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b). There may be tax consequences associated with the purchase of a qualified long-term care insurance contract, such as the tax deductibility of premiums and the exclusion from taxable income of benefits. The prospective insured is urged to consult with a qualified tax advisor."

(B) Policies which are not intended to be a qualified long-term care insurance contract. Include disclosure language substantially similar to the following: "This policy is not intended to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b). This policy will not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B. The prospective insured is urged to consult with a qualified tax advisor." Additionally, the insurer must disclose the criteria which result in the policy or certificate not being classified as a qualified long-term care insurance contract.

(17) ADDITIONAL FEATURES.

(A) (Indicate if medical underwriting is used.)

(B) (Describe other important features such as unintentional lapse as provided by §3.3841 of this title (relating to Unintentional Lapse and Reinstatement).

§3.3837. Reporting Requirements.

(a) Policy or certificate replacements and lapses. The purpose of this subsection is to specify requirements for insurers issuing long-term care insurance benefits in this state to report to the commissioner information on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses.

(1) Agent records.

(A) Each insurer must maintain records, for each agent, of that agent's number and dollar amount of replacement sales as a percentage of the agent's total number and amount of annual sales attributable to long-term care products, as well as the number and dollar amount of lapses of long-term care insurance policies sold by the agent and expressed as a percentage of the agent's total annual sales attributable to long-term care products.

(B) 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 agent activities regarding the sale of long-term care insurance.

(2) Reporting of 10 percent of agents. Each insurer must report by June 30 of every year the information indicated in the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form on the listing of the 10 percent of agents data as specified in Figure: 28 TAC §3.3837(a)(2) for the 10 percent of its agents with the greatest percentages of policy or certificate lapses and replacements during the preceding calendar year. Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(a)(2)

Long-Term Care Insurance
Replacement and Lapse Reporting
Form

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

For the State of ____________________ For the Reporting Year of ___________

Company Name: ______________________________________

Company Address: ____________________________________

____

Company NAIC Number: _________________

Contact Person: _____________________ Phone Number: (___)_________

Instructions

The purpose of this form is to specify the information regarding long-term care insurance policy replacements and lapses that insurers are required to report to the Commissioner of Insurance on a statewide basis. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The following two tables indicate the information required in reporting the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced by This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed by This Agent	Number of Lapses As % of Number Sold By This Agent

The following table indicates the number of replacement long-term care policies sold as a percentage of the insurer's total annual sales of such policies and the number of lapsed long-term care policies as a percentage of the insurer's total annual sales of such policies.

Company Totals

Company Name: ______________________________ Report Year _____

Replacement Policies Sold	
Annual Policies Sold	
Policies in Force (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Annual Policies Sold (as of the end of the preceding calendar year)	

% of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year)	
Policies Lapsed	
% of Policies Lapsed to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Policies Lapsed to Policies in Force (as of the end of the preceding calendar year)	

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(3) Reporting number of lapsed long-term care policies. Each insurer must report by June 30 of every year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

(4) Reporting number of replacement long-term care policies. Each insurer must report by June 30 of every year the number of replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

(b) Rescissions. Each insurer issuing long-term care insurance benefits in this state must maintain a record of all policy, contract, or certificate rescissions relating to such long-term care insurance benefits, both for coverage in this state and nationwide, except for those which the insured voluntarily effectuated, and must report this data for the preceding calendar year to the commissioner by June 30 of every year as indicated on Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies as specified in Figure: 28 TAC §3.3837(b). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(b)

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES

FOR THE STATE OF TEXAS

FOR THE REPORTING YEAR ________

Due: No later than June 30 annually for the preceding calendar year

Company Name: ______________________________

Address: ______________________________

____

Phone Number ______________________________

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates for the preceding calendar year. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form perrescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:
____
____

____

____

____

Signature

Name and Title (please print)

Date

Form Number LHL563(LTC)

(c) Claims denied by class of business.

(1) Definitions. For purposes of this subsection, the following terms have the following meanings.

(A) Claim--A request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(B) Denied--The insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

(2) Report of claims denied. Each insurer issuing long-term care insurance benefits in this state must maintain a record by class of business of the number of long-term care claims for long-term care services denied during the preceding calendar year in this state. The insurer must report the number of claims denied for each class of business expressed as a percentage of claims denied to the commissioner by June 30 of every year as indicated on Form Number LHL564(LTC) Long-Term Care Insurance Claim Denials Reporting Form as specified in Figure: 28 TAC §3.3837(c)(2). Each insurer must submit the

required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(c)(2)

Long-Term Care Insurance
Claim Denials Reporting Form

FOR THE STATE OF TEXAS

For the Reporting Year of ________________

Due: No later than June 30 annually for the preceding calendar year

Company Name: ____

Company Address: ____

____

Company NAIC Number: ____

Contact Person:_____________________________Phone Number: ________________________

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Claim" means a request for payment of benefits under an in-force policy regardless ofwhether the benefit claimed is covered under the policy or any terms or conditions of the policy have beenmet.

Indicate the manner of reporting by checking one of the boxes below.

☐ Per Claimant - counts each individual who makes one or a series of claim requests

☐ Per Transaction - counts each claim request

"Denied" means a claim that is not paid for any reason other than for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied forReporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 divided by Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit eligibility Criteria Not Met[4]		
11	• Other[5]		

1. The nationwide data may be viewed as a more representative and credible indicator where thedata for claims reported and denied for your state are small in number.
2. Example: home health care claim filed under a nursing home only policy.
3. Example: a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples: (i) a benefit trigger not met; (ii) certification by a licensed health care practitioner not provided; (iii) no plan of care.
5. Examples: duplicate submission, incomplete claim submission, advance billing.

Form Number LHL564(LTC)

(d) Long-Term Care Partnership Program. Each insurer that markets partnership policies in this state must report to the department by June 30 of each year the information required in §32.107 of the Human Resources Code, specifying the number of approved partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year in this state. The information required in this subsection must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

(e) Data report for non-partnership plans. Each insurer that markets long-term care insurance in this state must report to the department by June 30 of each year the number of non-partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing such non-partnership plans. The information required in this subsection must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(e)

LONG-TERM CARE POLICIES SOLD REPORTING FORM FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: ______________________________

NAIC ID Number: ______________________________

TDI ID Number: ______________________________

Instructions: Please include certificates and riders in the information reported below.

Long-Term Care Partnership Policy Type	Number Sold	Average Age
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		

Long-Term Care Non-Partnership Policy Type	Number Sold	Average Age
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		
Home Health Care (community-based services)		
Riders (attached to life policies, annuity contracts)		

Signature: ______________________________

Name: ______________________________

Title: ______________________________

Address: ______________________________

____

City/State/Zip Code: ______________________________________

Phone Number: ____________________________ EXT __________

E-mail Address: ______________________________________

Form Number LHL565(LTC)

(f) Suitability data. Each insurer issuing long-term care benefits in this state must report suitability data for this state for the preceding calendar year to the commissioner by June 30 of each year as indicated on Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in Figure: 28 TAC §3.3837(f)(1). Each insurer must submit the required information electronically in a format prescribed by the department on the department's website.

(1) Reporting form. A representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form is as follows:

Figure: 28 TAC §3.3837(f)(1)

LONG-TERM CARE SUITABILITY REPORTING FORM FOR THE REPORTING YEAR __________

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: ____

NAIC ID Number:____

TDI ID Number: ____

Suitability Data for Partnership Policies

Long-term Care Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total Numberof Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Choseto Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				

Suitability Data for Non-Partnership Policies

Long-term Care Non-Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total Numberof Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				
Home Health Care (community-based services)				
Riders (attached to life policies, annuity contracts)				

Signature: ______________________

Name: ______________________

Title: ______________________

Address: ______________________

____

City/State/Zip Code: ______________________

Phone Number: ______________________ EXT ____________

E-mail Address: ______________________

Form Number LHL566(LTC)

(2) Applicability.

(A) This subsection applies to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(B) This subsection does not apply to life insurance policies:

(i) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(ii) that provide the option of a lump-sum payment for those benefits; and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(g) Demonstration of compliance with applicable loss ratio standards. Each insurer must file by June 30 of each year the annual rate filing required by Insurance Code §1651.053(c) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the commissioner relating to loss ratios. The filing must be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. Such demonstration must be in addition to any demonstration required under §3.3831(c)(2)(B) - (D) of this title (relating to Standards and Rates) and must include the following information by calendar duration, separately by form number:

(1) calendar duration;

(2) first year issued;

(3) actual earned premium by duration;

(4) actual incurred claims;

(5) actual calendar duration loss ratio;

(6) anticipated calendar duration loss ratio; and

(7) number of insured lives.

§3.3842. Appropriateness of Recommended Purchase.

(a) In recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent must make reasonable efforts to determine the appropriateness of the recommended purchase or replacement.

(b) Each insurer, health care service plan, or other entity marketing long-term care insurance (issuer) must:

(1) 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;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer must develop procedures that take the following factors into consideration:

(1) the applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) 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

(3) 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.

(d) The issuer and, where an agent is involved, the agent, must make reasonable efforts to obtain the information set forth in subsection (c) of this section. The efforts must include presentation to the applicant, at or prior to application, the Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H). The issuer may request the applicant to provide additional information to comply with the issuer's suitability standards. The following requirements apply if the issuer requests such additional information on the personal worksheet:

(1) A copy of the issuer's Long-Term Care Insurance Personal Worksheet Form Number LHL560(LTC) that includes the additional information that is requested to comply

with the issuer's suitability standards must be filed with the department for approval prior to use.

(2) Any form filed pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) The filing should be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(e) The issuer must receive the completed personal worksheet from the applicant prior to the issuer's consideration of the applicant for coverage, except the completed personal worksheet does not need to be received by the issuer prior to the issuer's consideration of an applicant for coverage for employer group long-term care insurance for employees and their spouses.

(f) The sale or dissemination outside of the company or agency by the issuer or agent of information obtained through the completion of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, including any additional information provided to comply with the issuer's suitability standards, is prohibited.

(g) The issuer must use the suitability standards that it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(h) Agents must use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

(i) At the same time that the personal worksheet is provided to the applicant, Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance, containing the text specified in Figure: 28 TAC §3.3842(i)(7) must also be provided to the applicant. The following requirements and procedures apply to this form:

(1) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842(i)(7).

(2) The text as specified in Figure: 28 TAC §3.3842(i)(7) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3842(i)(7) if the insurer files the form for review and approval by the commissioner.

(3) The form must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) An insurer may add a company name and identifying form number to Form Number LHL567(LTC) as specified in Figure: 28 TAC §3.3842(i)(7) without obtaining commissioner approval.

(5) The Instructions to Company that are included in Figure: 28 TAC §3.3842(i)(7) are to aid the insurer in drafting the form and should not be included in the text of the form used by the insurer.

(6) If filing the form for review and approval as provided under paragraphs (2) and (3) of this subsection, the insurer must file the form with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(7) A representation of Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is as follows:

Figure: 28 TAC §3.3842(i)(7)

Things You Should Know Before You Buy
Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Instructions to Company: For single premium policies, delete both of the sentences in the second bullet, and fornoncancellable policies, delete the second sentence only in the second bullet.

	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, andsome of your joint assets. • Your choice of long-term care services may be limited if you arereceiving Medicaid. To learn more about Medicaid, contact your localor state Medicaid agency at 1-800-252-8263 or call 211.

Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a booklet entitled "Long-Term Care Insurance" published by the Texas Department of Insurance. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• The Texas Health Information Counseling and Advocacy Program (HICAP) offers free one-to-one counseling services, concerning whether a long-term care insurance is a suitable option for you, that can be accessed through the toll free number 1-800-252-9240. For insurance agent, insurance company and any other long-term care insurance information, you may call the Consumer Help Line of the Texas Department of Insurance at 1-800-252-3439.
Facilities	• Some long-term care insurance contracts provide for benefit payments in certain facilities only if the facilities are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments and to determine that payment for acovered service will be made if you move to a state that has a differentlicensing scheme for facilities than the one in which you purchased the policy.

Form Number LHL567(LTC)

(j) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with or similar to Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. This method, at the option of the issuer, may include phone call, fax, U.S. mail, email or any combination of these methods. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter and the requirements and procedures that apply:

Figure: 28 TAC §3.3842(j)

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financialneeds. We suggest that you review the information provided along with your application, including the booklet "Long-Term Care Insurance" published by the Texas Department of Insurance and the disclosure form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Texas Department of Insurance also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy. You may contact the Department at 1-800-252-3439 or you may go to the Department's web site at www.tdi.state.tx.us.

[You either did not provide any financial information or provided insufficient financial information for us to review.]

Instructions to Company: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Instructions to Company: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

______________________________________ ____________________

APPLICANT'S SIGNATURE **DATE**

Please return to [issuer] at [address] by [date].

Form Number LHL568(LTC)

(1) The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j) or be similar to the text specified in Figure: 28 TAC §3.3842(j).

(2) The text must be in at least 12-point type.

(3) The Instructions to Company that are included in Figure: 28 TAC §3.3842(j) are to aid the issuer in drafting the form and should not be included in the text of the letter sent to the applicant.

(4) The form number should not be included on the letter sent to the applicant.

(k) This section and the delivery requirements for the shopper's guide in §3.3840 of this title (relating to Requirements To Deliver Shopper's Guide) apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(l) This section and the delivery requirements for the shopper's guide in §3.3840 of this title do not apply to life insurance policies:

(1) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(2) that provide the option of a lump-sum payment for those benefits; and

(3) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies.

(a) Insurer requirements.

(1) Any insurer issuing long-term care insurance to an association, as defined in the Insurance Code §1251.052, must file with the department in accordance

with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) the following:

(A) the long-term care policy and certificate;

(B) a corresponding outline of coverage; and

(C) annual certification of the association's compliance with marketing standards for long-term care policies and certificates in accordance with Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in Figure: 28 TAC §3.3849(e)(1)(F).

(2) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the department the information required in this subsection.

(b) Advertisements. Advertisements for long-term care insurance must be filed with the department in accordance with §3.3838(1) of this title (relating to Filing Requirements for Advertising).

(c) Association disclosure requirements.

(1) An association must disclose in any long-term care insurance solicitation to its members:

(A) 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

(B) a brief description of the process under which the policies and the insurer issuing the policies were selected.

(2) If the association and the insurer have interlocking directorates or trustee arrangements, the association must disclose that fact to its members.

(d) Board approval requirements. The board of directors of associations selling or endorsing long-term care insurance policies or certificates must review and approve the insurance policies and certificates as well as the compensation arrangements made with the insurer.

(e) Insurer certification form.

(1) The following requirements and procedures apply to Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in Figure: 28 TAC §3.3849(e)(1)(F):

(A) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3849(e)(1)(F).

(B) The text of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form as specified in Figure: 28 TAC §3.3849(e)(1)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3849(e)(1)(F) if the insurer files the reformatted certification form for review and approval by the commissioner.

(C) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(E) Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form may be obtained from the Texas Department of Insurance, Life and Health Division, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or from the department's website at www.tdi.texas.gov/forms.

(F) A representation of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form is as follows:

Figure: 28 TAC §3.3849(e)(1)(F)

Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates

Due annually between January 1 and January 31 for the preceding calendar year

---

Company Name ______________________________

NAIC ID Number ______________________________

For Calendar Year ______________________________

Date Submitted ______________________________

TDI ID Number ______________________________

I hereby certify that:

Each association as defined in the Insurance Code §1251.052 to whom (company name) has issued a long-term care partnership policy or certificate or non-partnership policy or certificate during (calendar year) has met the requirements of the Texas Administrative Code §3.3849 (relating to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies).

Signature: _

Name: ______________________________

Title: ______________________________

Address: ______________________________

____

City/State/Zip Code: ____

Phone Number: ______________________________ EXT____________

E-mail Address: ____

Form Number LHL573(LTC)

(2) The initial certification must be submitted to the department between January 1, 2010, and January 31, 2010, for the calendar year 2009, and thereafter must be submitted annually between January 1 and January 31 for the preceding calendar year.

(3) Form Number LHL573(LTC) is an informational filing pursuant to §3.5(b)(1) of this title (relating to Filing Authorities and Categories) and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The annual completed certification form submitted pursuant to paragraphs (2) and (3) of this subsection should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE, NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES AND ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY
DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY
28 TAC §§3.3871, 3.3873, and 3.3874

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter Y, Division 4, under Insurance Code §§1651.004, 1651.107, and 36.001.

Insurance Code §1651.004 authorizes TDI to adopt reasonable rules necessary and proper to carry out Chapter 1651.

Insurance Code §1651.107 authorizes the Commissioner to adopt rules as necessary to implement Chapter 1651, Subchapter C.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates.

(a) Standards.

(1) General requirements. In addition to the required filing and approval pursuant to §3.3873 of this title (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the following requirements:

(A) the insured individual was a resident of Texas when coverage first became effective under the policy. If the policy or certificate is later exchanged for a different long-term care policy or certificate, the individual was a resident of Texas when coverage under the first policy became effective;

(B) the policy is intended to be a qualified long-term care insurance policy under the provisions of §3.3847 of this title (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations);

(C) the policy or certificate is issued with and retains inflation coverage that meets the inflation standards specified in §3.3872 of this title (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) based on the insured's then attained age;

(D) the effective date of the newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed. The insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer.

(2) Required disclosure notice.

(A) A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate. The required disclosure notice is set forth in Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(B) The following requirements and procedures apply to Form Number LHL569(LTC).

(i) The text in the notice must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ii) The text in the notice as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the commissioner.

(iii) Any form filed pursuant to clause (ii) of this subparagraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(iv) An insurer may add a company name and identifying form number to Form Number LHL569(LTC) as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) without obtaining commissioner approval.

(v) The Instructions to Company that are included in Figure: 28 TAC §3.3871(a)(2)(B)(vii) are to aid the insurer in drafting the form and should not be included in the disclosure notice provided by the insurer.

(vi) Any form filed pursuant to clause (ii) of this subparagraph should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(vii) A representation of Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates is as follows:

Figure: 28 TAC §3.3871(a)(2)(B)(vii)

Partnership Status Disclosure Notice for Long Term Care Partnership Policies/Certificates

Important Information Regarding the Texas Long-Term Care Insurance Partnership Program

Note: It is very important that you keep this Disclosure Notice with your Long-Term Care insurance Policy or Certificate.

Insured Name: ___________________________________

Policy Name: ____________________________________

Date of Issue: ____________________________________

The long-term care insurance policy [certificate] that you have purchased currently qualifies for the Texas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] may protect your assets through a feature known as an "Asset Disregard," under the Texas Medicaid program. In accordance with the Texas Insurance Code §1651.106, if the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the partnership program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the Texas Medicaid program.

Asset Disregard means that the amount of the policyholder's [certificate holders] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. ***The purchase of a Partnership policy, however, does not guarantee you the ability to disregard assets. In addition, the purchase of a Partnership Policy does not automatically***

qualify you for Medicaid.

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Texas Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

What Could Disqualify Your Policy [Certificate] Status as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. **Before you make any changes, you should consult with [insert name of insurance company] to determine the effect of a proposed change.** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you may not receive beneficial treatment of your policy [certificate] such as asset disregard under the Medicaid program of that State. The information contained in this Disclosure Notice is based on current Texas and Federal laws. These laws are subject to change.

Additional Information. If you have questions regarding your insurance policy [certificate] please contact [insert the name of insurer]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Texas Health and Human Services Commission by calling 1-800-252-8263 or 211.

Form Number LHL569(LTC)

(viii) Any policyholder that exchanges their policy for a partnership policy must be provided with the required Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ix) When an insurer is made aware that a policyholder or certificate holder has initiated action that will result in the loss of partnership status, the insurer must provide an explanation of how such action impacts the insured in writing. The insurer must also advise the policyholder or certificate holder on how to retain partnership status if possible.

(x) If a partnership plan subsequently loses partnership status, the insurer must explain to the policyholders or certificate holders in writing the reason for the loss of status.

(3) Commissioner certification. Under §1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, in implementing the Texas Long-Term Care Partnership Insurance Program (Partnership Program), may certify that long-term care insurance policies and certificates covered under the Partnership Program meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act and principally include certain specified provisions of the NAIC Long-Term Care Model Act and Model Regulations (adopted as of October 2000). In providing this certification, the commissioner may reasonably rely upon the certification by insurers of the policy forms that is made in accordance Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in Figure: 28 TAC §3.3873(a)(2)(F).

(b) Reporting requirements. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act, all issuers of partnership policies or certificates must provide regular

reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. Such information must include but not be limited to the following:

(1) notification regarding when insurance benefits provided under partnership policies or certificates have been paid and the amount of such benefits paid;

(2) notification regarding when such policies or certificates otherwise terminate; and

(3) any other information the Secretary determines is appropriate.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies.

(a) Prior approval requirements. Each long-term partnership policy or certificate, including any long-term care partnership endorsement, that is to be delivered or issued for delivery in this state must comply with the requirements specified in paragraphs (1) and (2) of this subsection before being delivered or issued in this state.

(1) Each long-term care partnership policy, certificate, or endorsement must be filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and subsections (b) and (c) of this section, as applicable.

(2) Each long-term care partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form, as specified in Figure: 28 TAC §3.3873(a)(2)(F). The following requirements and procedures apply to this certification form:

(A) The text in the certification form must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3873(a)(2)(F).

(B) The text in the certification form as specified in Figure: 28 TAC §3.3873(a)(2)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3873(a)(2)(F) if the insurer files the certification form for review and approval by the commissioner.

(C) Any certification form that is filed for approval pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use in any filing of a policy, certificate or endorsement submitted pursuant to subsection (c) or (d) of this section and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any certification form filed pursuant to subparagraph (B) of this paragraph should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(E) Form Number LHL570(LTC) may be obtained from the Texas Department of Insurance, Life and Health Division, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or from the department's website at www.tdi.texas.gov/forms.

(F) A representation of Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form is as follows:

Figure: 28 TAC §3.3873(a)(2)(F)

Long-Term Care Partnership Program Insurer Certification Form

Section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), authorizes the Texas Commissioner of Insurance upon implementing a qualified State long-term care insurance partnership program ("Qualified Partnership") to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act" respectively).

In order to provide the Commissioner of Insurance with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership Program of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

____
____
____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

____
____
____

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

____
____
____

Copies of each of the above referenced policy forms, including any riders and endorsements, shall be provided if required under the provisions of 28 TAC §3.3873 (pertaining to Filing Requirements For Long-Term Care Partnership Policies).

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in Section I.C above?

Yes___ No___ N/A___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes___ No___ N/A___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes___ No___ N/A___ C. Section 6C (relating to extension of benefits).

Yes___ No___ N/A___ D. Section 6D (relating to continuation or conversion of coverage).

Yes___ No___ N/A___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes___ No___ N/A___ F. Section 7 (relating to unintentional lapse).

Yes___ No___ N/A___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

Yes___ No___ N/A___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes___ No___ N/A___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes___ No___ N/A___ J. Section 12 (relating to minimum standards).

Yes___ No___ N/A___ K. Section 14 (relating to application forms and replacement coverage).

Yes___ No___ N/A___ L. Section 15 (relating to reporting requirements).

Yes___ No___ N/A___ M. Section 22 (relating to filing requirements for marketing).

Yes___ No___ N/A___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

Yes___ No___ N/A___ O. Section 24 (relating to suitability).

Yes___ No___ N/A___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Yes___ No___ N/A___ Q. Section 26 (the provisions relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702BJ(g)(4)).

Yes___ No___ N/A___ R. Section 29 (relating to standard format outline of coverage).

Yes___ No___ N/A___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in section I.C above?

Yes___ No___ N/A___ A. Section 6C (relating to preexisting conditions).

Yes___ No___ N/A___ B. Section 6D (relating to prior hospitalization).

Yes___ No___ N/A___ C. Section 8 (provisions relating to contingent nonforfeiture benefits).

Yes___ No___ N/A___ D. Section 6F (relating to right to return).

Yes___ No___ N/A___ E. Section 6G (relating to outline of coverage).

Yes___ No___ N/A___ F. Section 6H (relating to requirements for certificates under group plans).

Yes___ No___ N/A___ G. Section 6J (relating to policy summary).

Yes___ No___ N/A___ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes___ No___ N/A___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership Program of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the policy forms and endorsements identified in Section C above meet all of the requirements of the 2000 National Association of Insurance Commissioners' Long-Term Care Model Act and Model Regulations that are specified in the Federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) and further certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

________________________ Date

________________________ Name and Title of Officer of the Issuer

________________________ Signature of Officer of the Issuer

Form Number LHL570(LTC)

(b) Policies not previously approved. Any policy or certificate, including any endorsement, that has not been previously approved by the commissioner must comply with the requirements specified in paragraphs (1) - (4) of this subsection prior to an insurer offering the policy for sale in Texas as a partnership policy:

(1) The policy, certificate, or endorsement must be filed with the department and approved by the commissioner, and Form Number LHL570(LTC) as specified in subsection (a)(2)(F) of this section must be filed for each policy, certificate, or endorsement form submitted for partnership policy approval.

(2) The policy, certificate, or endorsement form must be in at least 10-point type.

(3) Any filing made pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The filing should be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(c) Previously approved policies. Insurers requesting to use a previously approved non-partnership policy form as a long-term care partnership policy must comply with the requirements specified in paragraphs (1) - (6) of this subsection prior to offering the policy for sale in Texas as a partnership policy:

(1) The insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in subsection (a)(2)(F) of this section and must include a copy of any endorsement that is needed to comply with partnership policy requirements.

(2) The policy form number(s) or other identifying information, such as certificate series, must be provided on Form Number LHL570(LTC) as a part of the filing.

(3) The filing must be approved by the commissioner prior to an insurer offering the policy for sale in Texas as a partnership policy.

(4) The policy or certificate does not have to be included in the filing if it has been previously filed and approved by the commissioner.

(5) Any filing made pursuant to this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(6) The filing should be submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates.

(a) Insurer training verification and certification requirements for agents. The following requirements apply to an insurer that is offering partnership policies or certificates in this state.

(1) The insurer is required to obtain verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course).

(2) Pursuant to the Insurance Code §1651.105(b), the insurer is required to certify to the commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection. The initial certification must be submitted on Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number

LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B).

(3) The insurer is required to maintain records of the verification required in paragraph (1) of this subsection for at least four years from the date the verification is received, and the department or its designee may review these records at any time.

(b) Agent training certification form requirements. The following requirements and procedures apply to Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A) and Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B):

(1) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3874(b)(6)(A) and in Figure: 28 TAC §3.3874(b)(6)(B).

(2) The text of Form Number LHL571(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(A) and the text of Form Number LHL572(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(B) are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3874(b)(6)(A) and Figure: 28 TAC §3.3874(b)(6)(B) if the insurer files the reformatted certification form for review and approval by the commissioner.

(3) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(4) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

(5) Form Number LHL571(LTC) and Form Number LHL572(LTC) may be obtained from the Texas Department of Insurance, Life and Health Division, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or from the department's website at www.tdi.texas.gov/forms.

(6) Representations of Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form and Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form are specified in subparagraphs (A) and (B) of this paragraph.

(A) A representation of Form Number LHL571(LTC) is as follows:

Figure: 28 TAC §3.3874(b)(6)(A)

Long-Term Care Partnership Agent Training
Certification Initial Reporting Form
To be submitted to the Department by June 30, 2009

Company Name ____________________

NAIC ID Number ____________________

Date Report Submitted ____________________

TDI ID Number ____________________

I hereby certify that:

Each individual who currently sells a long-term care benefit plan for (company name)under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care policies.

Signature: ____________________

Name: ____________________

Title: ____________________

Address: ____________________

____

City/State/Zip Code: ____________________

Phone Number: ____________________ EXT__________

E-mail Address: ____________________

Form Number LHL571(LTC

(B) A representation of Form Number LHL572(LTC) is as follows:

Figure: 28 TAC §3.3874(b)(6)(B)

Long-Term Care Partnership Agent Training Certification Form
To be submitted to the Department annually between January 1 and January 31 for the preceding year beginning in 2010

Company Name ______________________________

Reporting for Year ______________________________

NAIC ID Number ______________________________

Date Report Submitted ______________________________

TDI ID Number ______________________________

I hereby certify that for the annual period specified above:

Each individual who currently sells or who has sold a long-term care benefit plan for (company name) under the Long-term care Partnership Program completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care policies.

Signature: ______________________________

Name: ______________________________

Title: ______________________________

Address: ______________________________

____

City/State/Zip Code: ______________________________

Phone Number: ______________________ EXT__________

E-mail Address: ______________________________

Form Number LHL572(LTC)

(c) Agent training certification filing requirements. An insurer offering partnership policies or certificates in this state must submit for the initial certification to the department Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(A) and submit for the subsequent annual certifications to the department Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(B), to certify that each individual who sells a long-term care benefit plan for the insurer under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership insurance contracts and how they relate to other public and private coverage of long-term care policies.

(1) The initial certification Form Number LHL571(LTC) must be submitted to the department between June 1, 2009 and June 30, 2009, and the subsequent annual certification Form Number LHL572(LTC) must be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010.

(2) Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) of this title (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of this chapter.

(3) Any certification form submitted pursuant to this subsection should be filed with the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030.

SUBCHAPTER Z. EXEMPTION FROM REVIEW AND APPROVAL OF CERTAIN LIFE, ACCIDENT, HEALTH, AND ANNUITY FORMS AND EXPEDITION OF REVIEW
28 TAC §§3.4001, 3.4002, 3.4004, and 3.4005

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter Z under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 provides that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.4001. Purpose.

The purpose of this subchapter is to exempt certain life and accident and sickness policy forms and annuity contract forms from certain of the requirements of Insurance Code Chapter 1701. Chapter 1701 requires that these forms may not be delivered, issued, or used in Texas unless they have been filed for review for approval with the Texas Department of Insurance as provided in §1701.054. Insurance Code §1701.005(b) provides for exemption by the commissioner of policy forms from the requirements of Chapter 1701 under certain circumstances. This subchapter exempts the forms specified from the requirement that they either be approved before being used or reviewed after being used as provided in §1701.054. However, this subchapter does not exempt such forms from the requirement that they be filed before being used. An additional purpose of this subchapter is to expedite the review process of forms filed under Insurance Code Chapter 1701.

§3.4002. All Forms To Be Filed for Review Unless Specifically Exempted.

All life and accident and sickness policy forms and annuity contract forms intended for use in this state, including application, rider, or endorsement forms not specifically

exempted by this subchapter, must be filed to be reviewed and approved in accordance with Insurance Code §1701.051 and §1701.054.

§3.4004. Exempt Forms.

(a) Group and individual life forms. The group and individual life insurance forms specified in this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (b) of this section:

(1) group life insurance master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §§1131.003, 1131.051 - 1131.058, 1131.060, and 1131.064(b), listed in subparagraphs (A) and (B) of this paragraph:

(A) term policies and riders; and

(B) cash value and endowment policies with no more than five death benefit and/or premium changes;

(2) any alternate face pages filed subsequent to the original approval of a policy for use with multiple employer trusteed arrangements as defined in Insurance Code §1131.053;

(3) individual, joint life, and last survivor insurance forms, including applications, listed in subparagraphs (A)-(Q) of this paragraph:

(A) ordinary life;

(B) limited pay life with no more than five death benefit and/or premium changes;

(C) life paid up at specified ages with no more than five death benefit and/or premium changes;

(D) single premium life with no more than five death benefit changes;

(E) modified premium level death benefit life with no more than five premium changes;

(F) level premium life with no more than five death benefit changes;

(G) retirement income policies;

(H) level or decreasing term policies and riders;

(I) increasing term policies and riders;

(J) family plans;

(K) family income;

(L) family plan riders, including but not limited to children's term riders, dependent term riders, and spouse term riders;

(M) limited pay endowment with no more than five death benefit and/or premium changes;

(N) level premium endowment with no more than five death benefit changes;

(O) single premium endowment with no more than five death benefit changes;

(P) indeterminate premium policies with no more than five death benefit changes; and

(Q) variable life policies with a separate account only;

(4) rider forms listed in subparagraphs (A)-(K) of this paragraph:

(A) accidental death benefit riders;

(B) waiver of premium riders;

(C) guaranteed insurability riders;

(D) individual retirement accounts (IRA) (to include Roth and Simple IRA) riders;

(E) preliminary term riders;

(F) conversion riders;

(G) exchange riders;

(H) waiver of cost riders, including waiver of cost and monthly expense charge, and waiver of cost and premium payment;

(I) dividend option riders;

(J) additional insured riders; and

(K) additional insurance on base insured riders;

(5) endorsement forms listed in subparagraphs (A)-(K) of this paragraph:

(A) ORP endorsements;

(B) nontransferability endorsements;

(C) H.R. 10 endorsements;

(D) tax sheltered annuity endorsements;

(E) nonassignability endorsements;

(F) settlement option endorsements;

(G) individual retirement account endorsements (to include Roth and Simple IRA endorsements);

(H) unisex endorsements;

(I) loan endorsements;

(J) waiver of surrender charges on disability or confinement in a hospital or nursing home endorsements; and

(K) step-up or roll-up death benefit endorsements;

(6) limited refilings for life insurance which indicate only a change in the mortality table or interest rates for new issues under the policy form, or changes to the separate account for variable products.

(b) Exceptions. The provisions of subsection (a)(1) and (2) of this section do not apply to any group or individual life insurance forms providing the types of coverages set out in paragraphs (1) - (12) of this subsection:

(1) universal life;

(2) universal related life;

(3) adjustable life;

(4) variable life with a fixed account;

(5) business value;

(6) any forms containing a market value adjustment;

(7) deposit term;

(8) forms subject to Insurance Code Chapter 1153;

(9) any life insurance product used to fund prepaid funeral contracts;

(10) any form containing a persistency bonus provision, no-lapse premium provision, or other additional interest credit to the policy value provision (guaranteed or non-guaranteed), equity indexed provision, residual death benefit provision, accelerated death benefit provision, long-term care or other accident and health related benefit provision;

(11) applications for use with variable life or equity indexed life, or forms that contain a market value adjustment provision, a long-term care or other accident and health related benefit provision; or

(12) group life master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §1131.064, relating to discretionary groups.

(c) Group and individual annuity forms. The group and individual annuity forms, including applications, specified in paragraphs (1) - (7) of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms

are required by the laws of Texas, another state, or of the United States to be specifically approved or are otherwise excepted in subsection (d) of this section:

(1) single premium immediate annuities (including variable immediate annuities);

(2) deferred annuities used as structured settlement options;

(3) individual deferred annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability or confinement in a hospital or nursing home); two-tier values; or a market value adjustment:

(A) for purposes of this paragraph, and paragraph (4) of this subsection, "waiver of surrender charges" means a waiver of surrender charges which is applied to any amount greater than 10% of the surrender value;

(B) for purposes of this paragraph, and paragraph (4) of this subsection, "two-tier values" means values on an annuity available at the maturity date of the contract which are different, depending on whether the value is taken from the contract in a lump sum or left with the issuer for periodic payments, regardless of whether the different values are available at issue or later;

(4) group annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability or confinement in a hospital or nursing home), two-tier values, or a market value adjustment; group annuities that are guaranteed investment contracts (GICs), synthetic GICs, funding agreements, and unallocated group annuities funding pension plans;

(5) limited refilings for annuity products which indicate only a change in the mortality table or interest rates for new issues under the policy form, or changes to the separate account for variable products;

(6) variable annuities with a separate account only, which do not include a provision for guaranteed living benefits; and

(7) reversionary annuities.

(d) Exceptions. The provisions of subsection (c) of this section do not include any of the following annuity forms:

(1) annuities used to fund prepaid funeral contracts;

(2) variable annuities that contain guaranteed living benefit provisions;

(3) annuities that contain an equity indexed provision, long-term care or other accident- and health-related benefit provision;

(4) applications for use with variable annuities, equity indexed annuities, annuities that contain a market value adjustment provision, long-term care or other accident- and health-related provision;

(5) group annuity master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §1131.064, relating to discretionary groups.

(e) Group and individual accident and health forms. The group and individual accident and health insurance forms specified in paragraphs (1) - (3) of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (f) of this section:

(1) the group and blanket accident and health forms set out in subparagraphs (A) - (D) of this paragraph:

(A) any group accident and health master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto issued under authority of Insurance Code §1251.051 and §1251.052;

provided the forms issued under authority of Insurance Code §1251.052 are exempt only if delivered or issued for delivery to a labor union or organization of labor unions;

(B) any blanket accident and health master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under authority of Insurance Code §§1251.351 - 1251.358;

(C) any group master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §§1251.051, 1251.052, or 1251.053 providing Medicare Supplement coverage to an employer, multiple employer arrangement, or a labor union;

(D) any group master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §1251.051 and §1251.052 providing long-term care coverage to a single employer or a labor union through a policy which is delivered or issued for delivery outside of Texas;

(2) group and individual accident and/or health policies, contracts, certificates, applications, enrollment forms, riders, amendments, endorsements, and related forms (including but not limited to outlines of coverage, notices, rates, and conditional receipts) applicable thereto, providing coverages set forth in subparagraphs (A)-(K) of this paragraph:

(A) accident only (including occupational accident and other specified accident);

(B) accidental death and dismemberment;

(C) dental;

(D) in-patient confinement and basic hospital expense coverages (including policies with coverage on an indemnity or expense-incurred basis)

(E) vision;

(F) specified disease (including cancer, heart attack, stroke, and other specifically named diseases);

(G) disability coverages (including but not limited to income replacement, key-man, buy/sell, and overhead expense);

(H) policies designed to provide conversion coverages;

(I) other permitted coverages which are designed to supplement other in-force health insurance, including Champus supplements;

(J) group stop loss/excess loss policies containing an attachment point of $5,000 or more; and

(K) prescription drug policies; and

(3) any alternate face pages filed subsequent to the original approval of a policy for use with multiple employer trusteed arrangements as defined in Insurance Code §1251.053.

(f) Exceptions. The provisions of subsection (e) of this section do not apply to any of the insurance forms set out in paragraphs (1) - (6) of this section.

(1) The provisions of subsection (e)(2) of this section do not apply to any group or individual health insurance policy which provides, on a comprehensive basis for illness and injury, a combination of hospital, medical, and surgical coverages, including but not limited to any major medical policies and any limited benefit hospital, medical, and surgical policies as defined in §3.3079 of this title (relating to Minimum Standards for Limited Benefit Coverage).

(2) The provisions of subsection (e)(1) and (2) of this section do not apply to any Medicare supplement policies as defined in Insurance Code Chapter 1652, except as specifically provided in subsection (e)(1)(C) of this section.

(3) The provisions of subsection (e)(1) and (2) of this section do not apply to any long-term care policies as defined in Insurance Code Chapter 1651 (including but not limited to any policies providing nursing home or home health care coverages), except as specifically provided in subsection (e)(1)(D) of this section.

(4) The provisions of subsection (e)(1) and (2) of this section do not apply to any forms which contain preferred provider benefit plan provisions as defined in §§3.3701 - 3.3706 of this title (relating to Preferred Provider Plans).

(5) The provisions of subsection (e)(1) and (2) of this section do not apply to any group forms which are issued under the authority of Insurance Code §1251.056 (discretionary groups).

(6) The provisions of subsection (e)(2)(H) of this section do not apply to any policy subject to the provisions of Subchapter F of this chapter (relating to Group Health Insurance Conversion Privilege), except for policies providing conversion from a policy included as an exempt form in this section.

(g) Copies of previously approved forms. Any form not otherwise exempted under this subchapter that is an exact copy of a previously approved form is exempt from the review and approval requirements of Insurance Code Chapter 1701. Such forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). The certification form required to be used in filing the certification is "TEXAS POLICY FORM CERTIFICATIONS, Multi-Use Form," which also is to be utilized for filing certifications for file-and-use under Insurance Code §1701.052, as well as for corrections, resubmissions, substitutions, and filings for forms exempted from review and official action by this subchapter. Form "TEXAS POLICY FORM CERTIFICATIONS" is available from the Life and Health Division, has been filed with the Texas Register Division of the Secretary of State for public inspection, and is adopted by

reference in this subchapter. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating to Appendix).

(h) Copies of previously approved forms subsequently submitted in foreign language (non-English). Any form not otherwise exempted under this subchapter that is submitted in Braille as an exact copy of a previously approved form, or any form that has been translated into a foreign language from its previously approved English version, is exempt from the review and approval requirements of Insurance Code Chapter 1701. Such forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter. The certification form required to be used in filing the certification is the same as that described in subsection (g) of this section.

§3.4005. General Information.

(a) This section does not relieve any insurer or other licensee from complying with the Insurance Code or the rules and regulations of the Texas Department of Insurance.

(b) Insurers must cause all forms to comply with all required provisions of all applicable law including but not limited to the Insurance Code and the rules and regulations of the department. In addition to other legal requirements:

(1) forms may not contain any ambiguous, deceptive, misleading, unfair, inequitable or unjust wording or terminology;

(2) title headings or other indications of a form's provisions may not be misleading;

(3) forms may not contain any exception, exclusion, limitation, or reduction that is deceptive, unjust, unfair, encourages misrepresentation, or inequitable or that would deceptively affect the risk purported to be assumed in the general coverage of the contract; and

(4) forms may not be printed or otherwise reproduced in such a manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision.

(c) Every filing exempted from review by this subchapter must be accompanied by each item of information set out in paragraphs (1) - (3) of this subsection.

(1) A signed copy of the certification form which is entitled "TEXAS POLICY FORM CERTIFICATIONS, Multi-Use Form," which also is to be utilized for filing certifications for file-and-use under Insurance Code §1701.052, as well as for corrections, resubmissions, substitutions, and filings for previously approved similar forms. Form "TEXAS POLICY FORM CERTIFICATIONS" is available from the Life and Health Division, has been filed with the *Texas Register* Division of the Secretary of State for public inspection, and is adopted by reference in this subchapter. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating to Appendix).

(2) Any additional information or documentation generally required under the provisions of Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) A cover letter setting out the items in subparagraphs (A)-(C), as follows:

(A) that the filing is exempt;

(B) the particular section, paragraph and subparagraph of the section under which the filing is exempt; and

(C) a brief description of the benefits provided by the form.

SUBCHAPTER AA. LIMITED EXEMPTION FOR INSURANCE COVERAGE FROM THE REQUIREMENTS OF INSURANCE CODE CHAPTER 1701
28 TAC §§3.4101 - 3.4103 and 3.4105

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter AA under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 provides that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.4101. Purpose.

This subchapter provides for exempting certain contracts or coverage from the requirement in Insurance Code Chapter 1701 that such contracts or coverage be filed for review with the Texas Department of Insurance before being delivered, issued, or used in this state; this exemption is applicable only if the coverage is otherwise authorized for use in this state and is appropriate under Insurance Code Chapter 1701, as if no provision for exemption existed. The exemption is for 45 days from the effective date of the coverage or until a later date as provided in this subchapter. The department has determined that the filing of certain forms or coverage before it goes into effect is not desirable or necessary for the protection of the public, and further that the requirement in Insurance Code Chapter 1701 that such forms be filed for review with the Texas Department of Insurance before being delivered, issued, or used in this state may not practicably be applied to such forms or coverage prior to its issuance or delivery in Texas.

§3.4102. Coverage Which May Be Exempted.

The following classes of insurance coverage may be exempted:

(1) group life or accident or health insurance coverage delivered or issued for delivery to the groups authorized by Insurance Code §§1131.051, 1131.052, 1251.051, and 1251.052, insofar as it applies to a labor union as group policyholder if the coverage conforms to the following:

(A) it is a result of a collective bargaining agreement between a labor organization and an employer;

(B) it is required by the collective bargaining agreement to go into effect within 60 days of the final agreement;

(C) it is the subject of aggressive and knowledgeable bargaining in a fully arms-length fashion on the part of the policyholder; and

(D) due to the economic posture of the parties involved, it is impracticable to obtain prior approval before the policy is issued and delivered;

(2) group life or accident or health insurance coverage delivered or issued for delivery to the groups authorized by Insurance Code §1131.060 and §1251.052, if the coverage conforms to the following:

(A) it is the result of extensive bargaining over the benefits to be afforded and the rates to be charged;

(B) it is required by the policyholder to go into effect within 60 days of the final agreement between the parties;

(C) it is the subject of aggressive and knowledgeable bargaining in a fully arms-length fashion on the part of the policyholder; and

(D) due to the economic posture of the parties involved, it is impracticable to obtain prior approval before the policy is issued and delivered.

§3.4103. Obtaining Exemptions.

The exemption specified in §3.4102 of this title (relating to Coverage Which May Be Exempted) is conditioned as follows.

(1) The insurer has an affirmative duty to comply with the following:

(A) the insurer must file with the Texas Department of Insurance a statement signed by an officer of the company certifying that each of the conditions specified in either §3.4102(1) or (2) of this title (relating to Coverage Which May Be Exempted) is satisfied, and stating the name of the insured, the nature and extent of benefits, the date the parties concluded the agreement respecting insurance coverage, and the effective date of coverage;

(B) the insurer must inform the group policyholder in writing that the coverage is exempted from review by the Texas Department of Insurance for a limited time;

(C) the insurer must file the statement required by subparagraph (A) of this paragraph and a copy of the communication required by subparagraph (B) of this paragraph with the Texas Department of Insurance by the later of:

(i) 10 days from the date the parties concluded the agreement respecting the insurance coverage; or

(ii) 10 days from the effective date of coverage; and

(D) the insurer must submit the exempted forms for review with the Texas Department of Insurance in the usual manner prescribed by Insurance Code Chapter 1701, as soon as possible after:

(i) the effective date of coverage; or

(ii) the date the parties concluded the agreement respecting the insurance coverage. In no event may the insurer delay submission of the forms for review more than 45 days from the later of:

(I) the effective date of coverage; or

(II) the date the parties concluded the agreement respecting the insurance coverage.

(2) The insurance coverage must be authorized by and comply with the laws of this state.

§3.4105. Disciplinary Measures.

The Texas Department of Insurance may at any time revoke the exemption specified in this subchapter on the grounds that a company:

(1) has not complied with this subchapter; or

(2) by failing to abide by other applicable law is found to be unworthy of the exemption. The department may, after hearing, revoke that company's right to future exemptions under this subchapter and may also administer any sanction provided by law.

SUBCHAPTER CC. STANDARDS FOR ACCELERATION-OF-LIFE-INSURANCE BENEFITS FOR INDIVIDUAL AND GROUP POLICIES AND RIDERS
28 TAC §3.4317

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter CC under Insurance Code §§1111.053, 1701.060, and 36.001.

Insurance Code §1111.053 provides that the Commissioner may adopt rules to implement Chapter 1111, Subchapter B.

Insurance Code §1701.060 provides that the Commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.4317. Effective Date.

This subchapter, as adopted by the commissioner, applies to all life insurance contracts marketed, delivered, issued for delivery, or renewed in Texas on or after the effective date of the subchapter, which will be 20 days after the date the adopted subchapter is filed with the Office of the Secretary of State.

SUBCHAPTER EE. VALUATION OF LIFE INSURANCE POLICIES
28 TAC §3.4503 and §3.4506

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter EE under Insurance Code §§425.058(c)(3), 425.073, and 36.001.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by Commissioner rule for use in determining the minimum standard values under Chapter 425, Subchapter B.

Insurance Code §425.073 requires the Commissioner to adopt by rule a valuation manual and to determine the operative date of the manual.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.4503. Applicability.

This subchapter applies to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, and before January 1, 2017, subject to the

following exceptions in paragraph (1) of this section and conditions in paragraph (2) of this section. For all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2017, the requirements of the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, apply.

(1) Exceptions.

(A) This subchapter shall not apply to any individual life insurance policy issued on or after the effective date of this subchapter 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 subchapter, that guarantees the premium rates of the new policy. This subchapter also shall not apply to subsequent policies issued as a result of the exercise of such a provision, or a derivation of the provision, in the new policy.

(B) This subchapter shall not apply to any universal life policy that meets all the following requirements:

(i) secondary guarantee period, if any, is five years or less;

(ii) specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the 1980 CSO valuation tables and the applicable valuation interest rate; and

(iii) the initial surrender charge is not less than 100% of the first year annualized specified premium for the secondary guarantee period.

(C) This subchapter shall not apply to any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(D) This subchapter shall not apply to any variable universal life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts.

(E) This subchapter shall not apply to a group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(2) Conditions.

(A) Calculation of the minimum valuation standard for policies with guaranteed Nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies), or both, shall be in accordance with the provisions of §3.4506 of this title (relating to Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies)).

(B) Calculation of the minimum valuation standard for flexible premium and fixed premium universal life insurance policies, that contain provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period, shall be in accordance with the provisions of §3.4507 of this title (relating to Calculation of Minimum Valuation Standard for Flexible Premium and Fixed Premium Universal Life Insurance Policies That Contain Provisions Resulting in the Ability of a Policyowner to Keep a Policy in Force Over a Secondary Guarantee Period).

§3.4506. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than Universal Life Policies).

(a) Basic reserves. Basic reserves must be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy must use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums,

either one of the two adjustments described in paragraphs (1) or (2) of this subsection may be made.

(1) An insurer may use the adjustments described in this paragraph.

(A) Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment; and

(B) subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(2) An insurer may use the adjustments described in this paragraph.

(A) Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and

(B) subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Deficiency reserves.

(1) The deficiency reserve at any duration must be calculated:

(A) on a unitary basis if the corresponding basic reserve determined by subsection (a) of this section is unitary;

(B) on a segmented basis if the corresponding basic reserve determined by subsection (a) of this section is segmented; or

(C) on the segmented basis if the corresponding basic reserve determined by subsection (a) of this section is equal to both the segmented reserve and the unitary reserve.

(2) This subsection applies 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 §3.4505(b) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) and rate of interest.

(3) Deficiency reserves, if any, must be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in §3.4505(b) of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves).

(4) For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(c) 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 must use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if the select mortality factors are used, they must be the ten-year select factors incorporated into Insurance Code Chapter 425, Subchapter B. 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.

(d) Unusual pattern of guaranteed cash surrender values.

(1) 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 must 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.

(2) The reserves actually held subsequent to any unusual guaranteed cash surrender value must 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:

(A) 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:

(i) the date of the next unusual guaranteed cash surrender value, if any, that is scheduled after the valuation date; or

(ii) the mandatory expiration date of the policy; and

(B) 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

(C) the net to gross ratio is equal to clause (i) of this subparagraph divided by clause (ii) of this subparagraph as follows:

(i) 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;

(ii) the present value, at the beginning of the n year period, of the scheduled gross premiums payable during the n year period.

(3) For purposes of this subsection, a policy is considered to have an unusual pattern of guaranteed cash surrender values if any future guaranteed cash surrender value exceeds the prior year's guaranteed cash surrender value by more than the sum of:

(A) 110% of the scheduled gross premium for that year;

(B) 110% of one year's accrued interest on the sum of the prior year's guaranteed cash surrender value and the scheduled gross premium using the nonforfeiture interest rate used for calculating policy guaranteed cash surrender values; and

(C) 5% of the first policy year surrender charge, if any.

(e) 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:

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves must never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c) of this section.

(3) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves must never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (A) of this paragraph.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO mortality tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A reinsurance agreement will be considered YRT reinsurance for purposes of this subsection if only the mortality risk is reinsured.

(6) If the assuming company chooses this optional exemption, the ceding company's reinsurance reserve credit will be limited to the amount of reserve held by the assuming company for the affected policies.

(f) Optional exemption for attained-age-based yearly renewable term life insurance policies. At the option of the company, the approach described in this subsection for reserves for attained-age-based YRT life insurance policies may be used.

(1) Calculate the valuation net premium for each future policy year as the tabular cost of insurance for that future year.

(2) Basic reserves may never be less than the tabular cost of insurance for the appropriate period, as defined in subsection (c) of this section.

(3) Deficiency reserves.

(A) For each policy year, calculate the excess, if greater than zero, of the valuation net premium over the respective maximum guaranteed gross premium.

(B) Deficiency reserves may never be less than the sum of the present values, at the date of valuation, of the excesses determined in accordance with subparagraph (A) of this paragraph.

(4) For purposes of this subsection, the calculations use the maximum valuation interest rate and the 1980 CSO valuation tables with or without ten-year select mortality factors, or any other table adopted after the effective date of this regulation by the NAIC and promulgated by regulation by the commissioner for this purpose.

(5) A policy will be considered an attained-age-based YRT life insurance policy for purposes of this subsection if:

(A) 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

(B) 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.

(6) For policies that become attained-age-based YRT policies after an initial period of coverage, the approach of this subsection may be used after the initial period if:

(A) the initial period is constant for all insureds of the same sex, risk class and plan of insurance; or

(B) the initial period runs to a common attained age for all insureds of the same sex, risk class and plan of insurance; and

(C) after the initial period of coverage, the policy meets the conditions of paragraph (5) of this subsection.

(7) If this election is made, this approach must be applied in determining reserves for all attained-age-based YRT life insurance policies issued on or after the effective date of this subchapter.

(g) 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 conditions described in paragraphs (1) - (3) of this subsection are met.

(1) 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 for the final renewal period, n may be truncated or extended to reach the expiry age, provided that this final renewal period is less than ten years and less than twice the size of the earlier n-year

periods, and for each period, the premium rates on both the initial current premium scale and the guaranteed maximum premium scale are level;

(2) 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-year select mortality factors; and

(3) there are no cash surrender values in any policy year.

(h) Exemption from unitary reserves for certain juvenile policies. Unitary basic reserves and unitary deficiency reserves need not be calculated for a policy if the conditions described in paragraphs (1) - (3) of this subsection are met, based upon the initial current premium scale at issue.

(1) At issue, the insured is age twenty-four or younger;

(2) until the insured reaches the end of the juvenile period, which must occur at or before age twenty-five, the gross premiums and death benefits are level, and there are no cash surrender values; and

(3) 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.

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE
DIVISION 1. GENERAL PROVISIONS
28 TAC §3.5002

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter FF, Division 1, under Insurance Code §1153.005 and §36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.5002. Definitions.

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise.

(1) Account--The aggregate credit life insurance or credit accident and health coverage for a single class of business written through a single creditor, or written through more than one creditor under common control or ownership, by the insurer, whether coverage is written on a group or individual policy basis.

(2) Actual earned premium--The total of all premiums earned at the premium rates actually charged and in force during the experience period.

(3) Approved deviation by case--A premium rate or premium rate schedule adjusted in accordance with the deviation procedures set out in Division 6 of this subchapter (relating to Deviation Procedures).

(4) Automatic deviation--A premium rate that is filed pursuant to Insurance Code §1153.105.

(5) Average number of life years--The average of the number of group certificates or individual policies in force each month during the experience period (without regard to multiple coverage) times the number of years in the experience period.

(6) Case--Either a "single account case" or a "multiple account case" as follows:

(A) Single account case--An account that is at least 25% credible or, at the option of the insurer, any higher percentage as determined by the credibility table

set out in §3.5603 of this title (relating to Credibility Table). An insurer exercising this option must in writing notify, and obtain written approval of the commissioner, of the credibility factor it will use to define a "single account case." Once the commissioner is so notified, the credibility factor will remain in effect for the insurer until a different election has been filed in writing by the insurer and approved by the commissioner.

(B) Multiple account case--A combination of all the insurer's accounts of the same class of business with experience in this state, excluding all single account cases of the insurer defined in subparagraph (A) of this paragraph, or with the approval of the commissioner; "multiple account case" also means two or more accounts of the insurer, having like underwriting characteristics which are combined by the insurer for premium rating purposes, excluding all "single account cases" as defined in subparagraph (A) of this paragraph and other "multiple account cases" defined previously.

(7) Class of business--A class of business listed as follows:

(A) Class A--Commercial banks, savings and loan associations and mortgage companies;

(B) Class B--Finance companies and small loan companies;

(C) Class C--Credit unions;

(D) Class D--Production credit associations (agriculture and horticulture P.C.A.s);

(E) Class E--Dealers (including auto and truck, other dealers, and retail stores); and

(F) Class F--Other than subparagraphs (A) - (E) of this paragraph.

(8) Closed-end transactions--Credit transactions other than "open-end transactions" as defined in this section.

(9) Credibility factor--The degree to which the past experience of a case can be expected to occur in the future. The credibility factor is based either on the average

number of life years or the incurred claim count during the experience period as shown in the credibility table set out in §3.5603 of this title. The insurer must notify the commissioner in writing, and obtain written approval of the commissioner, about which of the two methods it will use in measuring credibility. Once the commissioner is so notified, the method will remain in effect for the insurer until a change has been filed with and approved by the commissioner.

(10) Credit disability--Credit Accident and Health.

(11) Earned premium at presumptive premium rate--Premium earned during the experience period at the presumptive premium rate set forth in §3.5206 of this title (relating to Presumptive Premium Rates). If the rate for a case is not the presumptive premium rate, premium earned at the presumptive premium rate must be determined in accordance with the conversion method set forth in Form CI-EP-L or Form CI-EP-DIS, as appropriate, provided by the department for that purpose, and set out in an attachment by the insurer to its deviation request form. The forms can be obtained from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. The forms can also be obtained from the department's internet website at www.tdi.texas.gov/forms.

(12) Experience--The earned premiums and incurred claims for a single or multiple account case. Experience will be the most recent experience in this state for a class of business, and may include the experience of the case while with a prior insurer to the extent necessary to achieve credibility.

(13) Experience period--The period of time for which experience is reported, but not for period longer than three years.

(14) Incurred claim count--The number of claims incurred for the case during the experience period. This means the total number of claims reported during the experience period (whether paid or in the process of payment) plus any incurred but not

reported at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. If a debtor has been issued more than one certificate for the same plan of insurance, only one claim is counted. If a debtor receives disability benefits, only the initial claim payment for that period of disability is counted.

(15) Incurred claims--The liability resulting from the happening of the contingency insured against whether paid, reported, not reported or resisted on accounting dates, valued by date of occurrence and, without reduction for reinsurance, at amounts, excluding claims expenses, sufficient to discharge the company from all liability and is equal to claims paid minus unreported claims beginning of period plus unreported claims end of period minus claim reserve beginning of period plus claim reserve end of period.

(16) Open-end transactions or revolving accounts--Transactions in which credit is extended by a creditor under an agreement whereby:

(A) the creditor reasonably contemplates repeated transactions;

(B) the creditor may impose a finance charge from time to time on an outstanding unpaid balance; and

(C) the amount of credit that may be extended to the debtor during the term of the plan (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

(17) Presumptive premium rate--The rate established by the commissioner and set out in §3.5206 of this title.

(18) Pro rata method--A method used in determining premium refunds based on the assumption that premiums are earned in equal increments over the term of the policy. The premium refunds are calculated by multiplying the original gross premium by a factor determined by the formula t/n, in which t is the number of months remaining

from its evaluation date to the end of the loan and n is the number of months in the original term.

(19) Rule of anticipation (aka the single premium method)--A method used in determining premium refunds in which the unearned premium is equal to the gross single premium for the remaining term and remaining benefits.

(20) Sum of the digits method, aka rule of 78 method--A method used in determining premium refunds in which an unearned premium factor is calculated by dividing the sum of the original number of monthly payments by the sum of the remaining number of monthly payments. The premium refunds are calculated by multiplying the original gross premium by a factor determined by the formula (t * (t+1)/(n * (n+1), in which t is the number of months remaining from its evaluation date to the end of the loan and n is the number of months in the original term.

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE
DIVISION 2 APPLICATIONS AND POLICIES
28 TAC §3.5103

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter FF, Division 2, under Insurance Code §1153.005 and §36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.5103. Policy Provisions.

Each individual policy or group certificate of credit life insurance or credit accident and health insurance delivered or issued for delivery in this state must, in addition to the other requirements of law, set forth:

(1) the name and home office mailing address of the insurer, and on group certificates of insurance, an identification of the master policy;

(2) the name and age or birth date of the insured debtor (or debtors, if joint life);

(3) the full amount of premium or the total identifiable insurance charge, if any, to the debtor, stated separately for credit life insurance and for credit accident and health insurance; however, if the indebtedness is an open-end transaction, there must be set forth, separately for credit life and credit accident and health insurance, the rate of insurance charge or payment per unit of coverage and how each charge is derived;

(4) the amount of insurance coverage;

(5) the effective date of insurance, and the termination date of insurance. The termination date may not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is an open-end transaction, in lieu of the termination date, the conditions of termination must be set forth;

(6) a description of the coverage;

(7) any and all exceptions, limitations, and restrictions to the coverage;

(8) a statement that the benefits, to the extent necessary to extinguish the unpaid amount of the indebtedness, will be paid to the creditor as first beneficiary, and will be applied by the creditor to reduce or extinguish such indebtedness; and a statement that wherever the insurance benefits may exceed the amount necessary to extinguish the indebtedness, any such excess must be paid by separate check or draft of the insurer to the insured debtor, if then living; otherwise, to a second beneficiary named by the debtor,

or a second insured debtor or, in the absence of such designation, to the surviving spouse or to the debtor's estate;

(9) a statement indicating that upon discharge of the indebtedness, the insurance will be terminated, but without prejudice to any claim originating prior to such termination, and that in all cases of termination prior to scheduled maturity, a refund of any unearned amount of premium paid by or charged to the debtor for insurance will be made in accordance with the appropriate formula set forth in §3.5901 of this title (relating to Refund of Unearned Premiums) and §3.5906 of this title (relating to Treatment of Partial Months). Such refund must be paid or credited to the account of the debtor, or paid to the second beneficiary, if the debtor is not living. No such refund is required if the total amount thereof is less than $3.00. (For insurance coverage subject to Finance Code Chapters 341, 342, and 345 - 348, a refund must be made, except that no cash refund will be required if the amount thereof is less than $1.00.)

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE
DIVISION 4. PRESUMPTIVELY ACCEPTABLE RELATION OF CREDIT LIFE INSURANCE BENEFITS TO PREMIUMS
28 TAC §3.5302

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter FF, Divisions 4, under Insurance Code §1153.005 and §36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.5302. Joint Credit Life Insurance.

(a) Joint lives, for purposes of credit life insurance written under Insurance Code Chapter 1153, mean only spouses or business partners, and such persons must be jointly and severally liable for repayment of the single indebtedness and be joint signers of the instrument of indebtedness. Endorsers and guarantors are not eligible for credit insurance coverage. Joint life coverage may not be written covering more than two lives. Jointly indebted persons may not both be covered separately at single life rates.

(b) Joint life rates may not be charged for single life coverage.

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE
DIVISION 6. DEVIATION PROCEDURES
28 TAC §3.5602 and §3.5610

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter FF, Division 6, under Insurance Code §1153.005 and §36.001.

Insurance Code §1153.005 provides that the Commissioner may adopt rules to implement Chapter 1153.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.5602. Request for an Approved Deviated Premium Rate.

A request for an approved deviated rate must be made in writing and must include all of the information which is required under this subchapter. It must be accompanied by a list of the creditors whose experience is the basis for such request, and must be attested to by an officer of the insurer. The use of any approved rate deviation approved by the

commissioner is limited to those creditors whose names appear on such list. No rate deviation may be used unless and until approved by the commissioner in writing. Any request for an approved deviated rate must be submitted to the commissioner through the Filings Intake Division in the manner prescribed on Form CI-DRF provided by the department for that purpose. The form can be obtained from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. The form can also be obtained from the department's internet website at www.tdi.texas.gov/forms. In order to provide the commissioner sufficient time for review, all requests for approved rate deviations must be submitted a minimum of 60 days prior to the proposed effective date of the approved deviated rate.

§3.5610. Determination of Approved Deviated Case Rates.

(a) For cases which are not of credible size, or have no experience, no approved deviation may be made in the presumptive premium rates under these deviation procedures; except that nothing herein may be construed as preventing any insurer from filing an automatic deviation pursuant to Insurance Code §1153.105.

(b) For purposes of this section: if the coverage for a single creditor which qualifies as a case has been in force with the insurer for less than the experience period:

(1) the claim experience of the creditor while covered by any prior insurer must be included to the extent necessary in determining the appropriate case ratios; and

(2) the experience considered in the determination of multiple state case rates must be Texas experience for the case unless the insurer makes the one-time election to use only nationwide experience. The election to use only nationwide experience must be accompanied by a certification that the insurer uses the same nationwide basis in determining the case ratios in each state in which the case has

experience. A grouping of states may be used subject to the same requirements of consistency and certification.

(c) Schedule of new case rates. When submitting a Request for Deviated Rate pursuant to §3.5602 of this title (relating to Request for an Approved Deviated Premium Rate) the insurer must also file a schedule of new case rates as determined by this section.

(d) Approved deviation request form. As required by §3.5602 of this title, any request for approved deviated rates must be submitted to the commissioner through the Filings Intake Division in the manner prescribed on the form provided by the department for that purpose. The form can be obtained from the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030. The form can also be obtained from the department's internet website at www.tdi.texas.gov/forms.

SUBCHAPTER JJ. 2001 CSO MORTALITY TABLE
28 TAC §§3.9101, 3.9103, 3.9104, and 3.9106

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter JJ under Insurance Code §§425.058(c)(3), 425.073, 1105.055(h), and 36.001.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by Commissioner rule for use in determining the minimum standard values under Chapter 425, Subchapter B.

Insurance Code §425.073 requires the Commissioner to adopt by rule a valuation manual and to determine the operative date of the manual.

Insurance Code §1105.055(h) specifies that the Commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.9101. Purpose.

The purpose of this subchapter is to recognize, permit, and prescribe the use of the 2001 Commissioners Standard Ordinary (CSO) Mortality Table in accordance with Insurance Code §425.058(c)(3) and §1105.055(h) and §3.4505 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves). For policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, provides applicable mortality tables.

§3.9103. 2001 CSO Mortality Table.

(a) At the election of the company for any one or more specified plans of insurance and subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after May 1, 2003, and before the date specified in subsection (b) of this section to which Insurance Code §425.058(c)(3) and §1105.055(h) and §3.4505 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) are applicable. If the company elects to use the 2001 CSO Mortality Table, it must do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table must be used in determining minimum standards for policies issued on and after January 1, 2009, and before January 1, 2017, to which Insurance Code §425.058(c) and §1055.055(h) and §3.4505 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) are applicable, except as provided in §§3.9601 - 3.9606 of this title (relating to Preneed Life Insurance Minimum Mortality Standards for Determining Reserve Liabilities and Nonforfeiture Values) for preneed life insurance policies and certificates. For policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, provides applicable mortality tables.

(c) The minimum basis for computation of values related to extended term benefits will be the 2001 CSO Mortality Table pursuant to the requirements of this subchapter.

(d) The Commissioner of Insurance adopts by reference the 2001 CSO Mortality Table. The table is available from the Texas Department of Insurance, Financial Regulation Division, Actuarial Office, MC-FRD, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/reports/life/ficso.html.

§3.9104. Conditions.

(a) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

(1) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Insurance Code §425.068,

and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits; or

(3) Smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables must be used.

(c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the company for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of §3.9105 of this title (relating to Applicability of the 2001 CSO Mortality Table to Chapter 3, Subchapter EE of this Title) relative to use of the select and ultimate form.

§3.9106. Gender-Blended Tables.

(a) For any ordinary life insurance policy delivered or issued for delivery in this state on and after May 1, 2003, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the company for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this subsection. For any ordinary life insurance policy delivered or issued for delivery in Texas on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, provides the applicable mortality tables.

(b) The company may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the National Association of Insurance Commissioners in December 2002. These blended tables are available from the Texas Department of Insurance, Actuarial Office, Financial Regulation Division, MC-FRD, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/reports/life/ficso.html.

(c) It is not, in and of itself, a violation of Insurance Code Chapter 541 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

SUBCHAPTER KK. EXCLUSIVE PROVIDER BENEFIT PLAN
28 TAC §§3.9202, 3.9203, 3.9206, 3.9211, and 3.9212

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter KK under Insurance Code §845.004 and §36.001, Government Code §533.0025, and Health and Safety Code §62.051.

Insurance Code §845.004 provides that the Commissioner must adopt rules as necessary to implement the Statewide Rural Health Care System Act.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

Government Code §533.0025 provides that the Medicaid-managed care delivery system must use the most cost-effective cost model, as determined by the Health and Human Services Commission.

Health and Safety Code §62.051 provides that the Commissioner of the Health and Human Services Commission may delegate to TDI the authority to adopt, with the

approval of the commission, any rules necessary to implement the Children's Health Insurance Program.

TEXT.

§3.9202. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Adverse determination--A determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary or not appropriate.

(2) Complaint--Any dissatisfaction, expressed by a complainant orally or in writing to the issuer, with any aspect of the issuer's operation, including plan administration; the denial, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions, expressed by a complainant. The term does not include a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the insured and does not include a provider's or insured's oral or written dissatisfaction with an adverse determination.

(3) Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility to deliver health care services.

(4) Emergency care--Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her

condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(5) Exclusive provider--A health care provider or an organization of health care providers who contract or subcontract to provide health care services to covered persons.

(6) Exclusive provider benefit plan (EPP)--A type of health care plan offered by an issuer that arranges for or provides benefits to covered persons through a network of exclusive providers, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or approved referral.

(7) Health care provider--Any person, corporation, facility, or institution licensed by the State of Texas (including physicians and practitioners listed in Insurance Code Chapter 1451) to provide health care services.

(8) Health care services--Any episodic or ongoing services such as pharmaceutical, diagnostic, behavioral health, medical, dental care, or chiropractic in either an inpatient or outpatient setting rendered by a health care provider for the purpose of treating, preventing, alleviating, curing, or healing illness, injury, or disease.

(9) Hospital--A licensed public or private institution as defined in Chapter 241, Health and Safety Code, or in Subtitle C, Title 7, Health and Safety Code.

(10) Independent review organization--An entity that is certified by the commissioner to conduct independent review under the authority of Insurance Code Chapter 4202.

(11) Institutional provider--A hospital, nursing home, or any other medical or health-related service facility caring for the sick or injured or providing care for other coverage which may be provided in a health insurance policy.

(12) Insured--For purposes of this subchapter, a person covered under an EPP.

(13) Issuer--An insurance company authorized to do business in Texas that contracts with the Health and Human Services Commission (HHSC) to provide CHIP or Medicaid coverage or contracts with or is sponsored by the System to issue an exclusive provider benefit plan.

(14) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(15) Limited provider network--A subnetwork within a network in which contractual relationships exist between health care providers, physician associations and/or physician groups which limit the insureds' access to only those health care providers in the subnetwork.

(16) Out-of-area benefits--Benefits that the EPP covers when its insureds are outside the geographical limits of the EPP service area.

(17) Physician--Anyone licensed to practice medicine in the State of Texas.

(18) Primary care physician or primary care provider--A health care provider who has been selected by the insured to provide initial and primary care, maintain the continuity of patient care, and who may initiate referrals for care.

(19) Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(20) Service area--A defined geographic area within which health care services are available and accessible to EPP insureds who live, reside, or work within that geographic area.

(21) Urgent care--Health care services provided in a situation other than an emergency which are typically provided in settings such as a health care provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the current health condition.

(22) Utilization review--A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review will not include elective requests for clarification of coverage.

§3.9203. Policy and Premium Rates.

(a) Disclosure of complaint system. An EPP policy or certificate must contain the Complaints and Appeals Process found in this subchapter. This information must include a clear and understandable description of the issuer's methods for resolving complaints. An issuer must provide any subsequent changes to the complaint system to insureds, which it may include in a separate document issued to the insured.

(b) Medically necessary covered services. If medically necessary covered services are not available through exclusive providers, the issuer, on the request of an exclusive

provider, must allow referral within a reasonable period to a non-network health care provider and must fully reimburse the non-network health care provider at the usual and customary or an agreed rate. The policy must provide for a review by a health care provider of the same specialty or a similar specialty as the type of health care provider to whom a referral is requested before the issuer may deny a referral.

(c) Schedule of premiums. An issuer must file the schedule of premium rates and formula or method for calculating the schedule of premium rates for covered health care services along with supporting documentation with the commissioner before it is used in conjunction with any EPP. The issuer must establish the formula or method in accordance with accepted actuarial principles and must produce premium rates that are not excessive, inadequate, or unfairly discriminatory, as well as premium rates that are reasonable with respect to benefits. An issuer may not alter the premium rates resulting from the application of the formula or method for an individual insured based on the status of that insured's health.

(1) An issuer must accompany each schedule of premium rates and formula or method for calculating the schedule of premium rates with the certification of a qualified actuary that, based on reasonable assumptions, the formula is appropriate to produce premium rates that are not excessive, inadequate, or unfairly discriminatory. An actuary is considered qualified if he or she:

(A) is a member of the American Academy of Actuaries; or

(B) is a Fellow of the Society of Actuaries.

(2) An issuer must accompany each formula or method for calculating the schedule of premium rates with adequate detail including assumptions to justify that the premium rates produced by the formula or method are not excessive, inadequate, or unfairly discriminatory.

(3) If the formula or method for calculating the schedule of premium rates and the resulting rates are to be continued beyond a one-year period, the issuer must file with the commissioner, no later than the anniversary of the effective date of the original filing, an actuarial statement stating that the issuer has applied the previously filed formula or method consistently, and that the rates charged have proven and are expected to continue to be adequate, not excessive, nor unfairly discriminatory. The issuer must include with this filing a reconciliation of actual benefits to a schedule of premium rates.

(4) To the extent that an entity contracting with the insured predetermines the schedule of premium rates, the issuer must submit the information described in this subsection and demonstrate that the issuer is able to provide the services for the contracted rates.

§3.9206. Quality Improvement and Utilization Management.

(a) An issuer must establish and maintain procedures to assure that the health care services provided to insureds are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. These procedures must include:

(1) mechanisms to assure availability, accessibility, quality, and continuity of care;

(2) an ongoing internal quality improvement program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, in all institutional and non-institutional contexts;

(3) a record of formal proceedings of quality improvement program activities and a means for maintaining documentation in a confidential manner. Quality improvement program minutes must be made available to the commissioner;

(4) a physician review panel to assist in reviewing medical guidelines or criteria and to assist in determining the prescription drugs to be covered by the EPP, if the plan contains a prescription drug benefit;

(5) an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of the issuer's evaluation of continuity and coordination of patient care and assessment of the quality of health care services provided to insureds;

(6) a mechanism for making available to the commissioner the clinical records of insureds for examination and review. Such records are confidential and privileged, and are not subject to Government Code, Chapter 552, Public Information, or to subpoena, except to the extent necessary to enable the commissioner to enforce this title; and

(7) a mechanism for the periodic reporting of quality improvement program activities to its governing body, providers, and appropriate organization staff. An issuer is also subject to the same quality improvement requirements as outlined in §11.1901 of this title (relating to Quality Improvement Structure).

(b) An issuer must establish a mechanism for utilizing independent review organizations as outlined in Insurance Code Chapter 4201.

§3.9211. Filing of Complaints.

Any person, including a person who has attempted to resolve complaints through an issuer complaint system process and who is dissatisfied with the resolution, may report an alleged violation of this subchapter to the Texas Department of Insurance at www.tdi.texas.gov or 1-800-252-3439.

§3.9212. Appeal of Non-Medicaid Adverse Determinations.

An issuer must perform utilization review in compliance with Insurance Code Chapter 4201 and must maintain procedures for notification, review, and appeal of an adverse determination, as defined by this section. An issuer must implement and maintain an internal appeal system for non-Medicaid adverse determinations that provides reasonable procedures for the resolution of an oral or written appeal initiated by an insured, a person acting on behalf of an insured, or an insured's provider of record concerning dissatisfaction or disagreement with an adverse determination.

SUBCHAPTER MM. PREFERRED MORTALITY TABLES
28 TAC §3.9401 and §3.9403

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter MM under Insurance Code §§425.058(c)(3), 425.073, 1105.055(h), and 36.001.

Insurance Code §425.058(c)(3) specifies that for an ordinary life insurance policy issued on the standard basis, to which Chapter 1105, Subchapter B, applies, the applicable table is any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by Commissioner rule for use in determining the minimum standard values under Chapter 425, Subchapter B.

Insurance Code §425.073 requires the Commissioner to adopt by rule a valuation manual and to determine the operative date of the manual.

Insurance Code §1105.055(h) specifies that the Commissioner may adopt by rule any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.9401. Purpose.

The purpose of this subchapter is to recognize and permit the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with Insurance Code §425.058(c)(3) and §3.4505 of this title (relating to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves). Policies issued on or after January 1, 2017, must follow the applicable mortality table requirements provided by the valuation manual adopted under Insurance Code Chapter 425, Subchapter B.

§3.9403. 2001 CSO Preferred Class Structure Table.

(a) Policies issued on or after January 1, 2007, and before January 1, 2017. At the election of the insurer, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this subchapter, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. Policies issued on or after January 1, 2017, must follow the mortality table requirements provided by the valuation manual adopted under Insurance Code Chapter 425, Subchapter B.

(b) Policies issued on or after May 1, 2003, and prior to January 1, 2007. At the election of the insurer and with the consent of the commissioner, for policies issued on or after May 1, 2003, and prior to January 1, 2007, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard subject to the conditions of §3.9404 of this title (relating to Conditions). In determining such consent, the commissioner may rely on the consent of the commissioner of the insurer's state of domicile.

(c) Requirement to make election. No election in subsection (a) or (b) of this section may be made until the insurer demonstrates that at least 20% of the business to be valued on this table is in one or more of the preferred classes.

(d) 2001 CSO Preferred Class Structure Mortality Table Treatment. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this subchapter, will be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of §§3.9101 - 3.9106 of this title (relating to 2001 CSO Mortality Table).

(e) Adoption by reference. The commissioner adopts by reference the 2001 CSO Preferred Class Structure Mortality Table. The table is available from the Texas Department of Insurance, Financial Regulation Division, Actuarial Office, MC-FRD, P.O. Box 12030, Austin, Texas 78711-2030 or on the internet by accessing the department's website at www.tdi.texas.gov/reports/life/ficso.html.

SUBCHAPTER NN. CONSUMER NOTICES FOR LIFE INSURANCE POLICY AND ANNUITY CONTRACT REPLACEMENTS
28 TAC §3.9503

STATUTORY AUTHORITY. The Commissioner adopts amendments to Subchapter NN under Insurance Code §§1114.006, 1114.007, and 36.001.

Insurance Code §1114.006 provides that the Commissioner by rule adopt or approve model documents to be used for consumer notices under Chapter 1114.

Insurance Code §1114.007 authorizes the Commissioner to adopt reasonable rules in the manner prescribed by Insurance Code, Chapter 36, Subchapter A, to accomplish and enforce the purpose of Chapter 1114.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

TEXT.

§3.9503. Consumer Notice Content and Format Requirements.

(a) The text contained in Figure: 28 TAC §3.9504(b), Figure: 28 TAC §3.9505(1) and Figure: 28 TAC §3.9505(2) must be in at least 10-point type and presented in the same order as indicated in each figure and without any change to the specified text, including bolding effects, except as provided in subsections (b), (c), and (d) of this section.

(b) Pursuant to §3.9506 of this title (relating to Filing Procedures for Substantially Similar Consumer Notices), in lieu of using the notices contained in Figure: 28 TAC §3.9504(b) or Figure: 28 TAC §3.9505(1), an insurer may file a notice with the department that is substantially similar to the text contained in Figure: 28 TAC §3.9504(b) or Figure: 28 TAC §3.9505(1) for review and approval by the commissioner. The commissioner will approve the notice if, in the commissioner's opinion, the notice protects the rights and interests of applicants to at least the same extent as the notices adopted in Figure: 28 TAC §3.9504(b) or Figure: 28 TAC §3.9505(1). An insurer required to send the notice specified in Figure: 28 TAC §3.9505(2) may not file a notice that is substantially similar to that figure for review and approval by the commissioner.

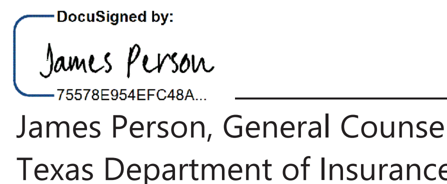
(c) Commissioner approval of a notice is not required if a notice promulgated or approved under this subchapter is used and amendments to that notice are limited to the omission of references not applicable to the product being sold or replaced. For purposes of this subchapter, a reference in any notice required under this subchapter to a product that is being sold or replaced is applicable if the reference could be applicable under any possible circumstances and therefore may not be omitted from the required notice.

(d) An insurer may add a company name and identifying form number to notices specified under this subchapter without obtaining commissioner approval.

(e) The promulgated forms specified in this subchapter are available upon request from the Texas Department of Insurance, Life and Health Division, Life and Health Lines, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030, or by accessing the department website at www.tdi.texas.gov/forms.

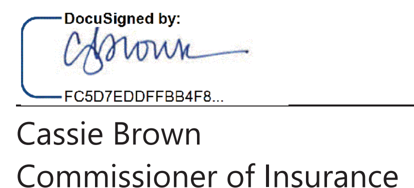
CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on April 20, 2022.



James Person, General Counsel
Texas Department of Insurance

The Commissioner adopts amended 28 TAC Chapter 3.



Cassie Brown
Commissioner of Insurance

Commissioner's Order No. **2022-7303**