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INTRODUCTION. The Texas Department of Insurance (TDI) proposes to amend 28 TAC Chapter 3, concerning life, accident, and health insurance and annuities. This rule proposal updates numerous sections throughout Chapter 3 to reflect Insurance Code §1105.0015 and §425.073, relating to the valuation manual. Insurance Code §1105.0015 specifies that the operative date of the valuation manual is the date on which the valuation manual adopted under Insurance Code Subchapter B, Chapter 425, becomes operative. Insurance Code §425.073 requires that TDI adopt a valuation manual, and specify the operative date of the manual. TDI has adopted the valuation manual and specified its operative date of January 1, 2017, in 28 Texas Administrative Code §3.9901. This proposal makes conforming changes throughout Chapter 3 to reflect the valuation manual and its operative date.

In addition, the proposal makes nonsubstantive amendments to numerous sections throughout subchapters in Chapter 3 to reflect the recodification of the Insurance Code; to update state agency names, websites, and physical addresses; and to correct typographical, punctuational, and grammatical errors.

TDI proposes to amend the following sections in 28 TAC Chapter 3: Subchapter A, §§3.2, 3.3, 3.4, 3.6, and 3.7; Subchapter B, §§3.104, 3.105, 3.107, 3.108, 3.114, 3.115, 3.124, and 3.127; Subchapter C, §§3.203 - 3.205; Subchapter D, §§3.301, 3.302, 3.308, 3.310, and 3.311; Subchapter E, §3.408; Subchapter G, §3.601; Subchapter H, §3.702 and §3.704; Subchapter I, §§3.802 - 3.806 and 3.811; Subchapter J, §3.909; Subchapter K, §§3.1001, 3.1002, and 3.1006; Subchapter L, §3.1101; Subchapter N, §§3.1303 - 3.1305; Subchapter O, §3.1403 and §3.1404; Subchapter Q, §§3.1601, 3.1602, 3.1605, 3.1606, and 3.1607; Subchapter R, Division 2, §3.1720; Subchapter R, Division 3, §3.1740 and §3.1742; Subchapter R, Division 4, §3.1760; Subchapter S, §§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; Subchapter T, §3.3321; Subchapter U, §§3.3401 - 3.3403; Subchapter Y, Division 2, §§3.3829, 3.3832, 3.3837, 3.3842, and 3.3849; Division 4, §§3.3871, 3.3873, and 3.3874; Subchapter Z, §§3.4001, 3.4002, 3.4004, and 3.4005; Subchapter AA, §§3.4101 - 3.4103 and 3.4105; Subchapter CC, §3.4317; Subchapter EE, §3.4503 and §3.4506; Subchapter FF, Division 1, §3.5002; Subchapter FF, Division 2, §3.5103; Subchapter FF, Division 4, §3.5302; Subchapter FF, Division 6, §3.5602 and §3.5610; Subchapter JJ, §§3.9101, 3.9103, 3.9104, and 3.9106; Subchapter KK, §§3.9202, 3.9203, 3.9206, 3.9211, and 3.9212; Subchapter MM, §3.9401 and §3.9403; and Subchapter NN, §3.9503.

EXPLANATION. The proposed amendments update numerous sections throughout Chapter 3 to reflect Insurance Code §1105.0015 and §425.073, relating to TDI's adoption of a valuation manual, and the operative date for that manual. The proposed 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 proposal also replaces "subchapter" or "chapter" with "title" where necessary, and removal of "the" in front of and commas following "Insurance Code" where appropriate. The proposal also replaces gender references to the commissioner with the phrase "the commissioner." These amendments, along with the amendments to correct punctuational, grammatical, and typographical errors and revise punctuation and capitalization for agency style, are made throughout the proposal and are not otherwise noted in the descriptions of amendments that follow, unless it is necessary or appropriate to provide additional context or explanation for a proposed amendment.

Descriptions of the proposed amendments in Subchapter A follow.

Section 3.2. Definitions. The proposal replaces a citation to Chapter 27 with Chapter 1502 and removes the hyphen from the word "non-forfeiture" to align with statutory language.

Section 3.3. Transmittal Information. The proposal updates the name and mailing address for the program area that can provide the checklist and form addressed by §3.3.

Section 3.4. General Submission Requirements. The proposal replaces a citation to Article 3.53 with Chapter 1153, replaces a citation to Article 3.50 §1(1) with §1131.051, replaces a citation to Article 3.50 §1(5) with §1131.053 in two instances, replaces a citation to Article 3.74 §4 with §1652.101, replaces a citation to Article 3.70-12 with Chapter 1651, replaces a citation to Article 3.42 with Chapter 1701, replaces a citation to Article 3.44a with Chapter 1105, replaces a citation to Article 3.44b with Chapter 1107, replaces a citation to Article 3.70-12 with §1651.053(c), replaces a citation to Article 3.50 §1(6) with §1131.064, replaces a citation to Article 3.51-6 §1(a)(6) with §1251.056, and replaces a citation to Article 3.51-6 §1(a)(2)(3) with §1251.053. In subsection (a), the proposal replaces "Filings Intake Division" with "Life and Health Division," to reflect the department's current organization. In subsection (b)(2), the proposal replaces a requirement to provide a fax number, if available, with a requirement to provide an email address, if available, within the list of information an insurer contact person is to provide to the Department upon form transmittal. The proposal replaces the word "Re-filings" with the word "Refilings" in the catchline to subsection (h). The proposal also removes the hyphen from the word "non-forfeiture" in nine instances to align with statutory language, and it inserts the phrase "of this paragraph" in subsection (r)(2) to clarify an internal reference.

Section 3.6. Certifications, Attachments, and Additional Information Requirements. The proposal replaces a citation to Article 3.50 §1(1) with §1131.051, replaces a citation to Article 3.50 §1(5) with §1131.053, replaces a citation to Article 3.50 §1 with Chapter 1131, replaces a citation to Articles 3.51-6 §(1)(a) and (2)(a) with Chapter 1251, replaces a reference to Article 3.50 §1(10) with §1131.060, and replaces a reference to Article 3.51-6 §1(a)(2) with §1251.052. The proposal also updates a reference to the heading of 28 TAC Chapter 26.

Section 3.7. Form Acceptance and Procedures. The proposal replaces a citation to Article 3.50, §1, with Chapter 1131; replaces a citation to Articles 3.51-6, §1(a) and §2(a),

with Chapter 1251; and replaces references to Articles 3.42(i), (j), and (k) with §§1701.055(a), 1701.055(d), and 1701.057(a).

Descriptions of the proposed amendments in Subchapter B follow.

Section 3.104. Incontestable Clause. The proposal replaces a citation to Article 3.44(3) with §1101.006.

Section 3.105. Statements of the Insured. The proposal replaces a citation to Article 21.16 with §705.004.

Section 3.107. Policy Loans. The proposal replaces a citation to Article 3.44c with Chapter 1110 in two instances.

Section 3.108. Automatic Nonforfeiture Benefits. The proposal replaces a citation to Article 3.44a with Chapter 1105.

Section 3.114. Dependent Child Riders and Family Term Riders. The proposal replaces a citation to Article 3.44a, §3, with §1105.006 in one instance and §1105.007 in another.

Section 3.115. Requirements for a Package Consisting of a Deferred Life Policy with an Accidental Death Rider Attached. The proposal replaces a citation to Article 3.42 with Chapter 1701.

Section 3.124. Provisions Relating to Dividends, Coupon Benefits, or Other Guaranteed Returns. The proposal replaces a citation to Article 3.11 with §841.253.

Section 3.127. Certain Prohibited Provisions. The proposal replaces "Board of Insurance Commissioners" with "Texas Department of Insurance" and replaces "State Board of Insurance" with "TDI."

Descriptions of the proposed amendments in Subchapter C follow.

Section 3.203. Instructions to Commissioner. The proposal replaces a reference to Article 3.42 with Chapter 1701, and it replaces "the board" with "the department."

Section 3.204. Material and Information for the Commissioner to Consider. The proposal replaces a reference to Article 21.21 with Chapter 541 and replaces a reference to Article 3.42 with Chapter 1701.

Section 3.205. Construction of Rules. The proposal replaces a reference to Article 21.21, §4, (6), with §541.056(c), and replaces a reference to "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter D follow.

Section 3.301. Purpose and Scope. The proposal replaces a reference to Chapter 21 with Chapter 541, and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.302. Policy Form Submission. The proposal replaces "State Board of Insurance" with "Texas Department of Insurance" and replaces "these sections" with "this subchapter."

Section 3.308. Minimum Nonforfeiture Values. The proposal replaces a reference to Article 3.44a with Chapter 1105, and it replaces the phrase "in the policy" with "by the policy" to align with language in Chapter 1105.

Section 3.310. Artificial Maximum Premiums Prohibited. The proposal replaces a reference to Article 3.44a with Chapter 1105; replaces a reference to Article 3.28 with Chapter 425, Subchapter B; and replaces "State Board of Insurance" with "Texas Department of Insurance."

Section 3.311. General Enforcement. The proposal replaces a reference to Article 21.21 with Chapter 541, and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter E follow:

Section 3.408. Mandatory Policy Provisions. The proposal replaces a reference to Chapter 20 with Chapter 842, replaces three references to the "Texas Department of

Human Services" with the "Texas Health and Human Services Commission," and replaces two references to "State Board of Insurance" with "Texas Department of Insurance."

Descriptions of the proposed amendments in Subchapter G follow.

Section 3.601. Purpose and Scope, Applicability, and Definitions Used in This Subchapter. The proposal replaces two references to Article 26.43 with §1501.260, replaces a reference to Chapter 20 with Chapter 842, replaces a reference to Chapter 20A with 843, and replaces a reference to Chapter 22 with Chapter 884. It also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter H follow.

Section 3.702. Definitions. The proposal replaces three references to Article 3.75 with Chapter 1152, deletes the defined terms "may" and "shall," renumbers defined terms as appropriate to reflect deletion of the defined terms, and clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.704. Separate Accounts. The proposal replaces a reference to Article 3.75 with Chapter 1152, and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter I follow.

Section 3.802. Definitions. The proposal replaces three references to Article 3.75 with Chapter 1152, removes "may" and "shall" as defined terms, renumbers definitions as appropriate to reflect deletion of the defined terms, and clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.803. Qualifications of Insurer to Issue Variable Life Insurance. The proposal replaces a reference to Article 3.75 with Chapter 1152 and "State Board of Insurance" with "Texas Department of Insurance," and it clarifies applicability by replacing the phrase "these sections" with "this subchapter." The proposal replaces a reference to “this rule” with “this section.”

Section 3.804. Insurance Contract and Filing Requirements. The proposal replaces six references to Article 3.44a with Chapter 1105, replaces "State Board of Insurance" with "Texas Department of Insurance," replaces a reference to Article 3.44c with Chapter 1110, and clarifies applicability by replacing the phrase "these sections" with "this subchapter." The proposal also replaces a reference to the numerical sections of Subchapter A with “Subchapter A.”

Section 3.805. Reserve Liabilities for Variable Life Insurance. The proposal replaces a reference to Article 3.28 with Chapter 425, Subchapter B.

Section 3.806. Separate Accounts. The proposal replaces a reference to Article 3.75 with Chapter 1152, replaces a reference to Article 3.44a with Chapter 1105, and replaces "State Board of Insurance" with "Texas Department of Insurance."

Section 3.811. Savings Clause. The proposal replaces "State Board of Insurance" with "Texas Department of Insurance" in two instances, revises the section to remove a reference to applicability of specific sections that are no longer in the Texas Administrative Code, and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter J follow.

Section 3.909. Notification and Disclosure Requirements. The proposal updates the section to remove language that is no longer necessary because the language addresses compliance in regard to actions occurring before the original effective date of Subchapter J.

Descriptions of the proposed amendments in Subchapter K follow.

Section 3.1001. Authority. The proposal replaces a reference to Article 3.25 with §982.303; replaces a reference to Article 3.28 with Chapter 425, Subchapter B; replaces a reference to Article 3.42 with Chapter 1701; replaces a reference to Article 3.55-1 with

Chapter 404; and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.1002. Purpose. The proposal replaces a reference to Article 3.28 with Chapter 425, Subchapter B; and it clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.1006. Early Warning Requirements. The proposal replaces the word "his" with "commissioner's" when referring to the commissioner's discretion, replaces the phrase "State Board of Insurance" with "Texas Department of Insurance," and clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter L follow.

Section 3.1101. Strengthened Reserves Pursuant to the Insurance Code, Article 3.28, §9. The proposal replaces a reference to Article 3.28, §9, with §425.067 in the section title; and it makes two such replacements in the text. The proposal also replaces a reference to Article 3.28, §3, with §425.053, and replaces "State Board of Insurance" with "Texas Department of Insurance." The proposal replaces an incorrect reference to Exhibit 8A of an annual statement with Exhibit 5A.

Descriptions of the proposed amendments in Subchapter N follow.

§3.1303. Standard. The proposal specifies that 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. The proposal provides additional clarifying information in a reference to an effective date based on a section of the Insurance Code that has been subsequently recodified, by inserting the word "former" and specifying the recodified section in the subsection (a) text, reading, "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 the *former* Insurance Code, Article 3.44a, §8 *(recodified in Insurance Code, Chapter 1105, Subchapter B, §§1105.051 - 1105.057),* for that policy form, the

following tables may be used...." The proposal also updates the mailing address and name of the program area that can provide the table referenced by the section, and it clarifies applicability by replacing the phrase "these sections" with "this section" and "this subchapter."

Section 3.1304. Alternate Rule. The proposal specifies that 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. The proposal provides additional clarifying information in a reference to an effective date based on a section of the Insurance Code that has been subsequently recodified, by inserting the word "former" and specifying the recodified section in the subsection (a) text, reading, "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 the *former* Insurance Code, Article 3.44a, §8 *(recodified in Insurance Code, Chapter 1105, Subchapter B, §§1105.051 - 1105.057),* for that policy form, in addition to the mortality tables that may be used...." The proposal also replaces "State Board of Insurance" with "Texas Department of Insurance" and updates the Life and Health Actuarial program area address.

Section 3.1305. Unfair Discrimination. The proposal replaces a reference to Article 21.21, §4(7)(a), with §541.057.

Descriptions of the proposed amendments in Subchapter O follow.

Section 3.1403. Alternate Tables. The proposal provides additional clarifying information in a reference to an effective date based on a section of the Insurance Code that has been subsequently recodified, by inserting the word "former" and specifying the recodified section in the subsection (a) text, reading, "For any policy of insurance delivered or issued for delivery in this state after the operative date of the *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...." The proposal makes this same change to the text in subsection (c). The proposal also replaces "State Board of Insurance" with "Texas Department of Insurance," updates the mailing address and name of the program area that can provide copies of the tables referenced by the section, and clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.1404. Conditions. The proposal replaces a reference to Article 3.28, §10, with §425.068.

Descriptions of the proposed amendments in Subchapter Q follow.

Section 3.1601. Purpose. The proposal replaces a reference to Article 3.28, §2A, with §425.054.

Section 3.1602. The proposal specifies that Subchapter Q applies to actuarial opinions for the 2005 valuation through the 2016 valuation, but that 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.

Section 3.1605. General Requirements. The proposal replaces a reference to Article 3.28, §2A, with §425.054; replaces a reference to Article 3.28, §6, with §425.064; replaces a reference to Article 3.28, §7, with §425.065; replaces a reference to Article 3.28, §10, with §425.068; and replaces a reference to Article 3.28, §11, with §425.069.

Section 3.1606. Statement of Actuarial Opinion Based on an Asset Adequacy Analysis. The proposal replaces a reference to Article 3.28 with Chapter 425, Subchapter B, adds inclusion of an email address to the information that must be provided with a certification under §3.1606(e), and for accuracy changes a reference to a table in paragraph to instead reference the figure that contains the table.

Section 3.1607. Description of Actuarial Memorandum Including an Asset Adequacy Analysis and Regulatory Asset Adequacy Issues Summary. The proposal updates the name and mailing address of the program area where a Texas domestic company must submit a regulatory asset adequacy issues summary. The proposal specifies that certain actuarial analysis may be submitted by email or paper copy, and provides the addresses for either option. The proposal also replaces the words "his or her" with "commissioner's" when referring to the commissioner's request.

Descriptions of the proposed amendments in Subchapter R, Division 2, follow.

Section 3.1720. Forms. The proposal updates the name and mailing address for the program area to which forms must be submitted under §3.1720.

Descriptions of the proposed amendments in Subchapter R, Division 3, follow.

Section 3.1740. Form Filing Requirements and Approval, Disapproval, or Withdrawal of Forms; Fees. In two instances, the proposal updates the name and mailing address for the program area to which submissions must be made under §3.1740. The proposal adds email address, if available, to the list of required information to be provided when filing forms. It also updates the mailing address for TDI's Office of the Chief Clerk.

Section 3.1742. Shopper's Guide. The proposal updates the mailing address and name for the program area that can provide the form addressed in §3.1742.

A description of the proposed amendment in Subchapter R, Division 4, follows.

Section 3.1760. Reporting Requirements. The proposal updates the name and mailing address for the program area that can provide the form addressed in §3.1760.

Descriptions of the proposed amendments in Subchapter S follow.

Section 3.3001. Applicability and Scope. The proposal replaces a reference to Article 3.53 with Chapter 1153. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter," and it addresses individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental

service associations, delivered, issued for delivery, or renewed in Texas prior to the effective date of §3.3001, providing that the regulations in effect at the time the policy or contract was delivered, issued for delivery, or renewed applies to such policies and contracts.

Section 3.3009. Policy Definitions of Sickness. The proposal replaces a reference to Article 3.70-3(A)(2) with §1201.208. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.3010. Policy Definition of Physician. The proposal replaces a reference to Article 3.70-2(B) with §1451.001.

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions. The proposal replaces a reference to Chapter 20 with Chapter 842.

Section 3.3039. Other Mandatory Policy Provisions. The proposal replaces a reference to Chapter 20 with Chapter 842, replaces three instances of "Texas Department of Human Services" with "Texas Health and Human Services Commission," replaces one reference to "said department" with the "Texas Health and Human Services Commission," and replaces three "State Board of Insurance" references with "Texas Department of Insurance."

Section 3.3052. Standards for Termination of Insurance Provision. The proposal replaces a reference to Article 3.70-2(C) with §1201.059, and it moves the phrase "this section" from one part of text to another to improve clarity. The proposal also replaces a reference to Article 3.70-7 with §1201.011.

Section 3.3057. Standards for Exceptions, Exclusions, and Reductions Provision. The proposal updates the name and mailing address for the program area that can provide the form addressed in §3.3057(b).

Section 3.3070. Minimum Standards for Benefits Generally. The proposal replaces a reference to Article 3.42 with Chapter 1701 and replaces a reference to Article 3.70-1(F)(1)(a)-(h) with §1201.104. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.3092. Format, Content, and Readability for Outline of Coverage. The proposal replaces a reference to Chapter 20 with Chapter 842. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter" and revises a reference to several sections by adding the sections' headings. The proposal deletes several unnecessary quotation marks.

Section 3.3100. Policy Readability Generally. The proposal replaces a reference to Article 3.70-3(A) with Chapter 1201, Subchapter E; replaces a reference to Article 3.70-3(B) with §§1201.219 - 1201.226; and replaces " article" with " subchapter."

Section 3.3101. Organization of Policy Format for Readability. The proposal replaces a reference to Article 3.70-2(A)(4) with §1201.054.

Section 3.3110. Effective Date; Applicability of Certain Provisions to Policies Deemed Continuous under Insurance Code. The proposal replaces two references to Article 3.70-13 with §1202.001 and adds the phrase "Insurance Code" before one reference to improve clarity. Amendments address individual accident and sickness insurance policies and subscriber contracts of hospital and medical and dental service associations, delivered, issued for delivery, or renewed in Texas prior to the effective date of §3.3001, and provide that the regulations in effect at the time the policy or contract was delivered, issued for delivery, or renewed applies to such policies and contracts. Changes also replace two references to the “effective date of this subchapter” with the date of December 22, 1997, which was the effective date of Subchapter S.

A description of the proposed amendment in Subchapter T follows.

§3.3321. Reporting of Multiple Policies. The proposal updates the name and mailing address for the program area that can provide the form addressed in §3.3321.

Descriptions of the proposed amendments in Subchapter U follow.

Section §3.3401. Purpose. The proposal replaces a reference to Article 3.70-2(E) with §1367.003. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.3402. Applicability and Scope. The proposal replaces a reference to Chapter 20 with Chapter 842 and clarifies applicability by replacing the phrase "these sections apply" with "this subchapter applies."

Section 3.3403. General Rules of Application. The proposal replaces 10 references to Article 3.70-2(E) with §1367.003 and replaces two "State Board of Insurance" references with "Texas Department of Insurance." The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter Y, Division 2, follow.

Section 3.3829. Required Disclosures. The proposal updates the mailing addresses and program area names where the forms referenced by §3.3829 can be obtained and where they must be filed, and it updates TDI's website address.

Section 3.3832. Outline of Coverage. The proposal replaces "Texas Department of Aging" with "Texas Health and Human Services Commission."

Section 3.3837. Reporting Requirements. The proposal updates the mailing address and program area name where filings must be submitted under §3.3837(g).

Section 3.3842. Appropriateness of Recommended Purchase. The proposal updates in two instances the mailing address and program area name where filings should be submitted under §3.3842.

Section 3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies.

The proposal updates the mailing addresses and program area names for where a reformatted form should be filed under §3.3849(e)(D), where the annual completed certification form should be filed under §3.3849(e)(1)(F)(4), and where the form referenced by §3.3849(e)(E) may be obtained, and it updates TDI's website address.

Descriptions of the proposed amendments in Subchapter Y, Division 4, follow.

Section 3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates. The proposal updates the mailing address and program area name where forms filed under §3.3871(a)(2)(B)(ii) should be submitted.

Section 3.3873. Filing Requirements for Long-Term Care Partnership Policies. The proposal, in four instances, updates the mailing addresses and program area names where forms or filings may obtained or should be filed, and it updates TDI's website address.

Section 3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. The proposal, in three instances, updates the mailing address and program area names where forms or filings may obtained or should be filed, and it updates TDI's website address.

Descriptions of the proposed amendments in Subchapter Z follow.

Section 3.4001. Purpose. The proposal replaces four references to Article 3.42 with Chapter 1701; replaces "State Board of Insurance" with "Texas Department of Insurance"; replaces a reference to Article 3.42, §(f), with §1701.005(b); and replaces a reference to Article 3.42, §(d)(1), with §1701.054. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.4002. All Forms To Be Filed for Review Unless Specifically Exempted. The proposal replaces a reference to Article 3.42, §(d), with §1701.051 and §1701.054. The

proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.4004. Exempt Forms. The proposal replaces three references to Article 3.42 with Chapter 1701; replaces a reference to Article 3.50 with §1131.003; replaces a reference to Article 3.50, §1(1), with §1131.051; replaces a reference to Article 3.50, §1(2), with §1131.052; replaces a reference to Article 3.50, §1(3), with §1131.054; replaces a reference to Article 3.50, §1(4), with §1131.057; replaces a reference to Article 3.50, §1(5), with 1131.053; replaces a reference to Article 3.50, §1(6)(b), with §1131.064(b); replaces a reference to Article 3.50, §1(7), with §1131.753; replaces a reference to Article 3.50, §1(7A), with §1131.056; replaces a reference to Article 3.50, §1(8), with §1131.058; replaces a reference to Article 3.50, §1(9), with §1131.0802; and replaces a reference to Article 3.50, §1(10), with §1131.060. The proposal also replaces a reference to Article 3.50, §1(5), with §1131.053; replaces two references to Article 3.50, §1(6)(a), with §1131.064; replaces three references to Article 3.51-6, §1(a)(1), with §1251.051; replaces four references to Article 3.5-6, §1(a)(2), with §1251.052; replaces a reference to Article 3.51-6, §2(a)(1) - (8), with §§1251.351 - 1251.358; replaces two references to Article 3.51-6, §1(a)(3), with §1251.053; replaces a reference to Article 3.74 with Chapter 1652; replaces a reference to Article 3.70-12 with Chapter 1651; replaces a reference to Article 3.51-6, §1(a)(6), with §1251.056; and replaces a reference to Article 3.42(c) with §1701.052. In addition, the proposal clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.4005. General Information. The proposal replaces a reference to Article 3.42(c) with §1701.052. The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter AA follow.

The heading of Subchapter AA is revised to replace a reference to Article 3.42 with Chapter 1701.

Section 3.4101. Purpose. The proposal replaces three references to Article 3.42 with Chapter 1701 and replaces two "State Board of Insurance" references with "Texas Department of Insurance." The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Section 3.4102. Coverage Which May Be Exempted. The proposal replaces Article 3.50, §1(1), with §1131.051; replaces two references to Article 3.50, §1(2), with §1131.052; replaces Article 3.51-6, §1(a)(1), with §1251.051; replaces Article 3.51-6, §1(a)(2), with §1251.052; and replaces Article 3.50, §1(1), with §1131.060.

Section 3.4103. Obtaining Exemptions. The proposal replaces four "State Board of Insurance" references with "Texas Department of Insurance" and replaces a reference to Article 3.42 with Chapter 1701.

Section 3.4105. Disciplinary Measures. The proposal replaces "State Board of Insurance" with "Texas Department of Insurance." The proposal also clarifies applicability by replacing the phrase "these sections" with "this subchapter."

Descriptions of the proposed amendments in Subchapter CC follow.

Section 3.4317. Effective Date; Grace Period. The proposal deletes language concerning a 90-day grace period for marketing, delivery, and renewal of certain life insurance policies that applied when the section was initially adopted in 1998.

A description of the proposed amendment in Subchapter EE follows.

Section 3.4503. Applicability. The proposal replaces a reference to the effective date of the subchapter with January 1, 2000, to prevent an unintentional lapse of applicability. The proposal specifies that 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.

Section 3.4506. Calculation of Minimum Valuation Standard for Policies with Guaranteed Nonlevel Gross Premiums or Guaranteed Nonlevel Benefits (Other than

Universal Life Policies). The proposal replaces a reference to Article 3.28 with Chapter 425, Subchapter B.

Descriptions of the proposed amendments in Subchapter FF, Division 1, follow.

Section 3.5002. Definitions. The proposal updates the mailing address and program area name for where forms referenced by §3.5002(11) may be obtained, replaces "web site" with "website," and updates TDI's website address.

Descriptions of the proposed amendments in Subchapter FF, Division 2, follow.

Section 3.5103. Policy Provisions. The proposal replaces a reference to Texas Civil Statutes, Article 5069, Chapters 3-6, 6A, 7, and 15, with Finance Code, Chapters 341, 342, and 345 - 348.

A description of the proposed amendment in Subchapter FF, Division 4, follows.

Section 3.5302. Joint Credit Life Insurance. The proposal replaces a reference to Article 3.53 with Chapter 1153.

Descriptions of the proposed amendments in Subchapter FF, Division 6, follow.

Section 3.5602. Request for an Approved Deviated Premium Rate. The proposal updates the mailing address and name for the program area from which the form referenced by §3.5602 may be obtained, replaces "web site" with "website," and updates TDI's website address.

Section 3.5610 Determination of Approved Deviated Case Rates. The proposal updates the mailing address and name of the program area from which the form addressed by §3.5610(d) may be obtained, replaces "web site" with "website," and updates TDI's website address.

Descriptions of the proposed amendments in Subchapter JJ follow.

Section 3.9101. Purpose. The proposal specifies that for policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, provides applicable mortality tables. The proposal replaces a reference to

Article 3.28, §3(a)(iii), with §425.058(c)(3) and replaces a reference to Article 3.44a, §8(e)(6), with §1105.055(h).

Section 3.9103. 2001 CSO Mortality Table. The proposal specifies that for policies issued on or after January 1, 2017, the valuation manual adopted under Insurance Code Chapter 425, Subchapter B, provides applicable mortality tables. The proposal replaces a reference to Article 3.28, §3(a)(iii), with §425.058(c)(3); replaces a reference to Article 3.44a, §8(3)(6), with §1105.055(h); updates the address for TDI's Life and Health Actuarial Program; and updates TDI's website address. Note that Subchapter O (related to Smoker-Nonsmoker Composite Mortality Tables) refers to the CSO Mortality Table in this section, including the application of the adopted valuation manual for policies issued on or after January 1, 2017.

Section 3.9104. Conditions. The proposal replaces a reference to Article 3.28, §10, with §425.068.

Section 3.9106. Gender-Blended Tables. The proposal specifies that 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. The proposal updates the mailing address and program area name for the area from which the blended tables addressed by §3.9106 may be obtained, updates TDI's website address, and replaces a reference to Article 21.21 with Chapter 541.

Descriptions of the proposed amendments in Subchapter KK follow.

Section 3.9202. Definitions. The proposal replaces a reference to Article 21.52 with Chapter 1451 and replaces a reference to Article 21.58C with Chapter 4202.

Section 3.9203. Policy and Premium Rates. The proposal replaces "that" with "than" in subsection (c)(3) text, reading, "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...."

Section 3.9206. Quality Improvement and Utilization Management. The proposal replaces a reference to Article 21.58A with Chapter 4201.

Section 3.9211. Filing of Complaints. The proposal updates TDI's website address.

Section 3.9212. Appeal of Non-Medicaid Adverse Determinations. The proposal replaces a reference to Article 21.58A with Chapter 4201.

Descriptions of the proposed amendments in Subchapter MM follow.

Section 3.9401. Purpose. The proposal specifies that 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. The proposal replaces a reference to Article 3.28, §3(a)(iii), with §425.058(c)(3) and deletes the effective date of former Article 3.28, §3(a)(iii).

Section 3.9403. 2001 CSO Preferred Class Structure Table. The proposal specifies that 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. The proposal updates the mailing address and name for the program area from which the table addressed by §3.9403 is available, and it updates TDI's website address.

Descriptions of the proposed amendments in Subchapter NN follow.

Section 3.9503. Consumer Notice Content and Format Requirements. The proposal updates the mailing address and name for the program area from which the promulgated forms specified in Subchapter NN are available, and it updates TDI's website address.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Justin Beam, chief clerk of the Texas Department of Insurance, has determined that during each year of the first five years the proposed amendments are in effect, there will be no measurable fiscal impact on state and local governments as a result of the proposed amendments. The proposed amendments update references to currently existing valuation manual requirements applicable to policies issued on or after January 1, 2017. The remainder of the amendments are limited to nonsubstantive changes, including updating statutory citations to reflect the recodification of the Insurance Code; updating website and physical addresses and state agency names to reflect changes; and correcting punctuational, grammatical, and typographical errors. Because the proposed amendments make no substantive changes, they do not add to or decrease state revenues or expenditures or change any requirements placed on local governments.

Mr. Beam does not anticipate any measurable effect on local employment or the local economy as a result of this proposal because the proposed amendments do not make any substantive changes.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed amendments are in effect, Mr. Beam expects that administering the proposed amendments will have the public benefit of ensuring that TDI's rules are accurate and transparent by reflecting updated Insurance Code references and correct state agency names and addresses and by eliminating errors in punctuation, grammar, and typography.

Mr. Beam expects that the proposed amendments will not increase the cost of compliance for stakeholders because the amendments do not impose substantive changes.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic effect on small or micro businesses or on rural communities. The proposed amendments are nonsubstantive and update and correct existing rules. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an

owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on December 6, 2021. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on December 6, 2021. If TDI holds a public hearing, TDI will consider comments both written and those presented at the hearing.

SUBCHAPTER A. SUBMISSION REQUIREMENTS FOR FILINGS AND DEPARTMENTAL ACTIONS RELATED TO SUCH FILINGS.
28 TAC §§3.2, 3.3, 3.4, 3.6, and 3.7

STATUTORY AUTHORITY. TDI proposes 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 rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Subchapter A implements Insurance Code Chapters 1153, 1251, 1273, and 1701.

TEXT.

§3.2. Definitions.

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

(1) - (3) (No change.)

(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) (No change.)

(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 [~~non-forfeiture~~] values for life insurance or annuities;

(B) - (D) (No change.)

(7) - (8) (No change.)

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

(A) - (D) (No change.)

(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 [~~27~~]).

(10) (No change.)

§3.3. Transmittal Information.

(a) All filings submitted pursuant to this subchapter must [~~shall~~] be accompanied by the department's transmittal checklist except for the documents listed in §3.1(11)(B) of this title [sub~~chapter] (r~~elating to Scope), which must ~~[sha~~ll] 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 [Filings ~~Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149~~104, ~~Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas, 78701], or b~~y accessing the department's website at www.tdi.texas.gov/forms [www.tdi.s~~tate.tx.us~~].

(b) The transmittal checklist must [~~shall~~]:

(1) (No change.)

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

(A) (No change.)

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

(C) (No change.)

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

(E) - (F) (No change.)

(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 [~~subchapter~~] (relating to Filing Authorities and Categories);

(H) - (J) (No change.)

(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 [~~subchapter~~] (relating to Certifications, Attachments, and Additional Information Requirements).

(ii) - (iii) (No change.)

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

(3) (No change.)

(c) The transmittal form must [~~shall~~]:

(1) (No change.)

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

(A) (No change.)

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

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

(D) (No change.)

(d) - (e) (No change.)

§3.4. General Submission Requirements.

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

(b) Contact person [~~Person~~]. A company submitting a filing to the department must [~~shall~~]:

(1) (No change.)

(2) provide the contact person's name, address, telephone number, and if available, email address [~~fax number~~] 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 [~~shall~~]:

(A) - (B) (No change.)

(4) (No change.)

(c) Form specifications [~~Specifications~~]. Any filing submitted pursuant to this subchapter must [~~shall~~] comply with the following:

(1) Filings submitted in paper format must [~~shall~~]:

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

(B) - (E) (No change.)

(2) Any form submitted must [~~shall~~] be designated by a form number that:

(A) - (B) (No change.)

(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 [~~Article 3.53~~]; 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 [~~26~~].

(d) Specimen language [~~Language~~] and specimen fill-in material [~~Specimen Fill-in Material~~].

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

(2) Life and annuity forms must [~~shall~~] be completed with fill-in material for specimen age 35. If the form is not issued at age 35, the fill-in material should [~~shall~~] 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 [~~shall~~] be filled in for the age at issue for which the greatest reduction in benefits is made. The fill-in material must [~~shall~~] be for the longest premium paying period available under the form.

(e) Variable material [~~Material~~].

(1) For all forms, any variable material in a form must [~~shall~~] be bracketed and [~~shall~~] 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 [~~non-forfeiture~~] assumptions generally cannot be considered variable material.

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

(1) must [~~shall~~] identify each provision with a unique form number that:

(A) - (B) (No change.)

(2) (No change.)

(3) must [~~shall~~] 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 [~~shall~~] provide the certifications required in §3.6(a)(8) of this title [~~subchapter~~] (relating to Certifications, Attachments, and Additional Information Requirements).

(g) Insert page filings [~~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 [~~shall~~] identify each insert page with a unique form number that:

(A) - (B) (No change.)

(2) (No change.)

(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 [~~shall~~] 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 [~~shall~~] provide the certifications required in §3.6(a)(8) of this title [~~subchapter~~].

(h) Limited, partial refilings [~~Partial Re-filings~~]. Limited, partial refilings must [~~shall~~] contain the change and any additional actuarial information necessary for a comprehensive review of the filing(s).

(i) Outline of coverage [~~Coverage~~]. An outline of coverage must [~~shall~~] 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 [~~Coverages~~].

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

(2) Group life forms submitted pursuant to Insurance Code §1131.051 or §1131.053 must [~~Article 3.50 §1(1) or (5) shall~~] be accompanied by the certification required in §3.6(a)(7) of this title [~~subchapter~~].

(k) Complete submission [~~Submission~~] of policy [~~Policy~~] or contract forms [~~Contract Forms~~]. For a submission to be considered complete, the submission must [~~shall~~] include the following:

(1) - (5) (No change.)

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

(1) - (2) (No change.)

(m) Previously approved [~~Approved~~] or exempted forms [~~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 [~~shall~~] 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 [~~Use~~] of previously approved [~~Previously Approved~~] or exempted forms [~~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 [~~Certificate~~] for policies [~~Policies~~] or contracts issued outside [~~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 [~~shall~~] include all specific descriptions and required information as follows:

(1) policy forms for which the rate filing applies must [~~shall~~] 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 [~~Article 3.53~~] and Subchapter FF of this chapter must [~~shall~~] include the rate information;

(3) group and individual Medicare supplement filings submitted under Insurance Code §1652.101 [~~Article 3.74 §4,~~] and Subchapter T of this chapter (relating to Minimum Standards for Medicare Supplement Policies) must [~~shall~~] include the applicable rate schedule and experience by plan;

(4) group and individual long-term care forms submitted under Insurance Code Chapter 1651 [~~Article 3.70-12~~] and Chapter 3, Subchapter Y of this title [~~chapter~~] (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies) must [~~shall~~] include the rate schedule;

(5) all individual accident and health filings submitted under Insurance Code Chapter 1701 must [~~Article 3.42 shall~~] include the rate schedule; and

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

(q) Actuarial information [~~Information~~].

(1) Each life filing, including riders, insert pages, or limited partial refilings, which changes the nonforfeiture [~~non-forfeiture~~] values of a particular policy or certificate must [~~shall~~] 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) (No change.)

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

(iii) (No change.)

(iv) any other calculations necessary to verify nonforfeiture [~~non-forfeiture~~] 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 [~~shall~~] 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 [~~shall~~] be provided.

(II) actuarial proof must [~~shall~~] be provided that:

(-a-) cash surrender values meet the minimum requirements of Insurance Code Chapter 1105 [~~Article 3.44a~~];

(-b-) - (-c-) (No change.)

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

(C) A statement must [~~shall~~] be provided certifying that all policies or certificates, in addition to the specimen language and fill-in material, will have premiums, reserves, and nonforfeiture [~~non-forfeiture~~] values calculated in a manner consistent with the information furnished with the specimen language and fill-in material. Any qualifications to such certification must [~~shall~~] 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 [~~shall~~] be provided to meet the minimum requirements of Insurance Code Chapter 1107 [~~Article 3.44b~~] and specify the guaranteed interest rates, the maximum surrender charges, and any other maximum charges applicable in the determination of nonforfeiture [~~non-forfeiture~~] values. If the company intends to change the guaranteed interest rates specified in the form, notification must [~~shall~~] be submitted to the department prior to the change. The notification must [~~shall~~] 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 [~~chapter~~] (relating to Policy Form Review).

(A) For variable annuities, the actuarial information must [~~shall~~] provide the information required in this paragraph and the information required by §3.705 of this title [~~chapter~~] (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 [~~shall~~]:

(i) - (iii) (No change.)

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

(I) - (II) (No change.)

(III) show that the minimum guaranteed values prior to the adjustment are not less than the minimum nonforfeiture [~~non-forfeiture~~] values required by law; and

(v) (No change.)

(3) Group and individual Medicare supplement (including Medicare SELECT) rate filings must [~~shall~~] 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 [~~shall~~] be accompanied by supporting actuarial information as required by Subchapter Y of this chapter; and

(B) annual reports must [~~shall~~] include the rates, rating schedule, and supporting documentation as required by Insurance Code §1651.053(c) [~~Article 3.70-12, §4(b)~~].

(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 [~~shall mean~~] the cumulative increase with respect to such premium considered over a 12-month period.

(A) - (E) (No change.)

(6) Discretionary group filings must [~~shall~~] be accompanied by supporting actuarial information as required by Insurance Code §1131.064 [~~Articles 3.50-§1(6)~~] and §1251.056 [~~3.51-6 §1(a)(6)~~].

(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) - (C) (No change.)

(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 [~~subchapter~~] (relating to Scope), a fee of $100 is required.

(E) - (F) (No change.)

(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) - (J) (No change.)

(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) - (C) (No change.)

(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 [~~subchapter~~], 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 [~~subchapter~~], 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 [~~Articles 3.50, §1(5) and 3.51-6, §1(a)(3)~~], a fee of $50 is required.

(G) - (H) (No change.)

(3) (No change.)

(4) Filings as described in §3.1(11)(B) of this title [~~subchapter shall~~] require no filing fee.

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

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

(1) A filing must [~~shall~~] include the following certifications, as applicable:

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

(i) - (v) (No change.)

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

(i) - (ii) (No change.)

(iii) the company has reviewed the filing;[~~,~~] and

(iv) (No change.)

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

(A) - (B) (No change.)

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

(A) - (C) (No change.)

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

(A) - (D) (No change.)

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

(A) - (F) (No change.)

(6) A company submitting a form as a resubmission of a previously disapproved form must [~~shall~~] provide the certification specified in paragraph (1) of this

subsection, and on the transmittal checklist must [~~shall~~] provide the following information and certification(s):

(A) - (F) (No change.)

(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 [~~Article 3.50 §1(1) or (5) shall~~] complete the appropriate certification on the transmittal checklist certifying that the policy will [~~shall~~] 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 [~~subchapter~~] (relating to General Submission Requirements) must [~~shall~~], 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 [~~subchapter~~] (relating to Filing Authorities and Categories) must [~~shall~~], in addition to the certification specified in paragraph (1) of this subsection, complete the appropriate certification on the transmittal checklist certifying:

(A) - (B) (No change.)

(C) the form filed meets the criteria specified in §3.4004 of this title [~~chapter~~] (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 [~~chapter~~] (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 [~~chapter~~] (relating to Newly Licensed Insurers); and

(F) (No change.)

(b) A company must [~~shall~~] 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 [~~chapter~~] (relating to Format, Content, and Readability for Outline of Coverage), §3.3102(g) of this title [~~chapter~~] (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 [~~shall~~]:

(1) on [~~On~~] the transmittal checklist, specify the specific group type under which the form is being filed by indicating the appropriate section [~~paragraph~~] as set forth in Insurance Code Chapter 1131 and Chapter 1251 [~~Articles 3.50 §1 and 3.51-6 §§(1)(a) and (2)(a)~~], 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 [~~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 [~~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 [~~shall~~] comply with all filing requirements set forth in Chapter 26 of this title. [~~(relating to Small Employer Health Insurance Regulations);~~]

(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 [~~Articles 3.50 §1(10), 3.51-6 §1(a)(2)~~], 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 [~~shall submit~~]:

(i) - (ii) (No change.)

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

(i) - (ii) (No change.)

(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 [~~shall~~] notify the department of any subsequent additions of participating associations upon enrollment and [~~shall~~] 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 [~~shall~~] be accompanied by a copy of the trust agreement;

(ii) must [~~shall~~] 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 [~~shall submit~~]:

(I) - (II) (No change.)

(d) (No change.)

§3.7. Form Acceptance and Procedures.

(a) Acceptance or rejection [~~Rejection~~].

(1) - (2) (No change.)

(b) Accepted filings [~~Filings~~].

(1) (No change.)

(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 [~~chapter~~] (relating to Procedures for Corrections to Non-Compliant Exempt Forms).

(3) (No change.)

(c) Request for correction [~~Correction~~].

(1) - (5) (No change.)

(d) Disapproval of a form [~~Form~~].

(1) The department may disapprove any form if:

(A) - (B) (No change.)

(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 [~~the~~] Insurance

Code Chapter 1131 and Chapter 1251 [~~Articles 3.50 §1 and 3.51-6 §§1(a) and 2(a),~~] and §21.2702(1) and (2) of this title (relating to Definitions).

(2) (No change.)

(e) Withdrawal of approval [~~Approval~~].

(1) (No change.)

(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) [~~Article 3.42(i), (j), or (k)~~].

(3) (No change.)

(f) Departmental notice [~~Notice~~] of action [~~Action~~]. The department will [~~shall~~] 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) - (3) (No change.)

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

(5) (No change.)

(6) Companies must [~~shall~~] 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 [~~shall~~] 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. TDI proposes 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 rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Section 3.104 implements Insurance Code §1101.006. Section 3.105 implements Insurance Code §705.004. Section 3.107 implements Insurance Code Chapter 1110. Section 3.108 and §3.114 implement Insurance Code Chapter 1105. Section 3.115 and §3.127 implement Insurance Code §1701.060. Section 3.124 implements Insurance Code §841.253.

TEXT.

§3.104. Incontestable Clause.

(a) The policy must provide that it will [~~shall~~] be incontestable not later than two years from its date as provided in [~~the~~] Insurance Code §1101.006 [~~, Article 3.44(3)~~]. If a reinstatement is contested for misrepresentation, then no representation other than one causing the reinstatement may be used to contest the policy. Any [~~, 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) - (e) (No change.)

§3.105. Statements of the Insured.

(a) The policy must provide that all statements made by the insured will [~~shall~~], in the absence of fraud, be deemed representations and not warranties. The policy may provide that statements made on behalf of the insured will [~~shall~~] 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) - (2) (No change.)

(3) they do not attempt to permit the insurer to avoid liability on grounds less stringent than under [~~the~~] Insurance Code §705.004 [~~, Article 21.16,~~] or other applicable law.

§3.107. Policy Loans.

(a) - (d) (No change.)

(e) [~~The~~] Insurance Code Chapter 1110 [~~, Article 3.44c,~~] deals with interest rates. Insurers may comply with Chapter 1110 [~~Article 3.44c~~] 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) - (h) (No change.)

(i) The loan clause must provide that failure to repay any such advance, or to pay interest thereon, will [~~shall~~] not void the policy until the total indebtedness thereon to the company equals [~~shall equal~~] or exceeds [~~exceed~~] 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 [~~shall~~] be exacted as a prerequisite to any such loan.

§3.108. Automatic Nonforfeiture Benefits.

(a) Nonforfeiture values are governed by [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~].

(b) - (c) (No change.)

§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 [~~is~~] acceptable:

(1) - (2) (No change.)

(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 [~~the~~] Insurance Code §1105.007 [~~, Article 3.44a, §3~~]; or

(4) (No change.)

(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 [~~the~~] Insurance Code §1101.006 [~~, Article 3.44, §3,~~] with respect to the coverage for each insured from the date the coverage for that insured becomes effective.

(c) (No change.)

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

(a) - (c) (No change.)

(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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42,~~] or other laws.

(e) - (g) (No change.)

§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 [~~shall~~] be treated as definite contract benefits and valued in accordance with [~~the~~] Insurance Code §841.253 [~~, Article 3.11~~].

(b) (No change.)

(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) - (4) (No change.)

§3.127. Certain Prohibited Provisions.

(a) (No change.)

(b) The policy may not contain the words "Approved by the Texas Department of Insurance [~~Board of Insurance Commissioners~~]," "Approved by TDI [~~the State Board of Insurance~~]," "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. TDI proposes 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 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 rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Section 3.203 implements Insurance Code Chapter 1701. Section 3.204 implements Insurance Code Chapter 1701 and Chapter 541. Section 3.205 implements Insurance Code §541.056(c).

TEXT.

§3.203. Instructions to Commissioner.

From and after the effective date hereof, the commissioner will [~~shall~~] not approve any "certain participating" policy form as defined herein. The commissioner will [~~shall~~] proceed to withdraw approval, under authority of Insurance Code Chapter 1701 [~~Article 3.42~~], 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 [~~shall~~] be predicated, the department [~~board~~] hereby finds and declares as follows:

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

(2) (No change.)

§3.204. Material and Information for the Commissioner to [~~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) - (2) (No change.)

(3) any other matters set forth in Insurance Code Chapter 541 [~~Article 21.21~~] 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 [~~he shall~~] disapprove such policy under the provisions of [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~].

§3.205. Construction of Rules. This subchapter may [~~These sections shall~~] not be construed to prohibit the use of any provision authorized by [~~the~~] Insurance Code §541.056(c) [~~, Article 21.21, §4, (6),~~] 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. TDI proposes 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 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 rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Subchapter D implements Insurance Code §543.001.

TEXT.

§3.301. Purpose and Scope.

(a) This subchapter is [~~These sections are~~] promulgated to regulate life insurance policies which have the following characteristics:

(1) - (2) (No change.)

(b) A major purpose of this subchapter [~~these sections~~] 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 [~~insure~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 541 [~~21~~]. This subchapter is [~~These sections are~~] 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 [~~State Board~~] 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 [~~these sections~~];

(2) that advertising and solicitation will be in compliance with this subchapter [~~these sections~~];

(3) - (4) (No change.)

(b) (No change.)

§3.308. Minimum Nonforfeiture Values.

The minimum basis for cash values is stated in [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~], wherein the adjusted premiums are required to be computed as a "uniform percentage of the respective premiums specified by [~~in~~] 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 [~~shall~~] 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 [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~], or reserves as provided in [~~the~~] Insurance Code Chapter 425, Subchapter B [~~, Article 3.28~~].

(b) As a condition precedent to policy form approval, there must [~~shall~~] 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 [~~shall~~] not be construed as a determination by the Texas Department [~~State Board~~] 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 [~~these sections~~] 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 [~~the~~] Insurance Code Chapter 541 [~~, Article 21.21~~].

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

STATUTORY AUTHORITY. TDI proposes 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 rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Section 3.408 implements Insurance Code §1204.153.

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 [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], 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 [~~Department of Human Services~~]" whenever:

(1) the Texas Health and Human Services Commission [~~Department of Human Services~~] is paying benefits under [~~the~~] 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) (No change.)

(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 [~~Department of Human Services~~].

(c) With respect to any policy forms approved by the Texas Department [~~State Board~~] 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 [~~State Board~~] of Insurance as being in compliance with this section and the provisions of the Insurance Code.

(d) (No change.)

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

STATUTORY AUTHORITY. TDI proposes amendments to Subchapter G under Insurance Code §§1501.010, 1501.260, and 36.001.

Insurance Code §1501.010 provides that the Commissioner adopt rules to implement the purpose of Chapter 1501 and meet the minimum requirements of federal law.

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.

CROSS-REFERENCE TO STATUTE. Section 3.601 implements Insurance Code §1501.260.

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 [~~the~~] Insurance Code §1501.260 [~~, Article 26.43,~~] 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 [~~These sections establish~~] the plain language requirements and minimum score for readability for such health benefit plans or forms, in accordance with [~~the~~] Insurance Code §1501.260 [~~, Article 26.43~~]. This subchapter [~~These sections~~] also establishes [~~establish~~] procedures that health carriers must follow to demonstrate and assure compliance with the new requirements.

(b) Applicability. This subchapter applies [~~These sections apply~~] 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 [~~These sections do~~] 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 [~~These sections~~] also does [~~do~~] not apply to any health benefit plan forms approved by the commissioner under department rules before January 1, 1994.

(c) Definitions.

(1) - (4) (No change.)

(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 [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], a

health maintenance organization under [~~the~~] Insurance Code[~~,~~] Chapter 843 [~~20A~~], and a stipulated premium company under [~~the~~] Insurance Code[~~,~~] Chapter 884 [~~22~~].

(6) (No change.)

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

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Subchapter H implements Insurance Code §1152.101 and §1152.002.

TEXT.

§3.702. Definitions.

The following words and terms, when used in this subchapter [~~these sections~~], [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) - (3) (No change.)

(4) General account--All assets of the insurer other than assets in separate accounts established pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], 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) [~~May--Is permissive.~~]

[~~(6)~~] 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 [~~shall~~] be determined at least monthly.

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

(7) [~~(8)~~] Separate account--A separate account established pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

[~~(9) Shall--Is mandatory.~~]

(8) [~~(10)~~] 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 [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~]. 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 [~~shall~~] establish one or more separate accounts pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~].

(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 [~~shall~~] be in writing, and the commissioner has [~~shall have~~] 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 [~~shall~~] not without prior written approval of the commissioner, employ in any material manner any person who:

(A) - (C) (No change.)

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

(b) Amounts in the separate account. The insurer must [~~shall~~] 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) (No change.)

(d) Limitations on ownership.

(1) A separate account may [~~shall~~] 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 [~~these sections~~], 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] not be changed without first filing such change with the commissioner.

(1) Any change filed pursuant to this subsection will [~~shall~~] 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 [~~his or her~~] 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 [~~he or she~~] 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) - (4) (No change.)

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

(6) (No change.)

(h) Standards of conduct. Every insurer seeking approval to enter into the variable annuity business in this state must [~~shall~~] 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 [~~shall be~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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) - (3) (No change.)

(4) such investment advisory contract must [~~shall~~] 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 [~~he or she~~] 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. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Subchapter I implements Insurance Code §1152.101.

TEXT.

§3.802. Definitions. The following words and terms, when used in this subchapter [~~these sections~~], [~~shall~~] have the following meanings, unless the context clearly indicates otherwise.

(1) - (9) (No change.)

(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 [~~shall be~~] 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) (No change.)

(12) General account--All assets of the insurer other than assets in separate accounts established pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], 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) (No change.)

[~~(14) May--Is permissive.~~]

(14) [~~(15)~~] 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) [~~(16)~~] Net cash surrender value--The maximum amount payable to the contract owner upon surrender.

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

(17) [~~(18)~~] Person--An individual, corporation, partnership, association, trust, or fund.

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

(19) [~~(20)~~] Separate account--A separate account established pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], or pursuant to the corresponding section of the insurance laws of the state of domicile of a foreign or alien insurer.

(20) [~~(21)~~] 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.

[~~(22) Shall--Is mandatory.~~]

(21) [~~(23)~~] 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) [~~(24)~~] 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 [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], 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 [~~shall~~] not deliver or issue for delivery in this state any variable life insurance contracts unless:

(A) (No change.)

(B) after having complied with the provisions of [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~], 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 [~~he or she~~] has considered among other things the following:

(i) - (ii) (No change.)

(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 [~~contract holders~~] in this state. The commissioner will [~~shall~~] consider, among other things:

(I) - (II) (No change.)

(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 [~~shall~~] 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 [~~State Board~~] 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 [~~rule~~]:

(A) - (B) (No change.)

(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 [~~shall~~] include a description of the investment objectives intended for the separate account;

(D) - (G) (No change.)

(H) the provisions of subparagraphs (A) - (G) of this paragraph will [~~shall~~] 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 [~~shall~~] establish and maintain a written

statement specifying the standards of suitability to be used by the insurer. Such standards of suitability must [~~shall~~] specify that no recommendation will [~~shall~~] be made to an applicant to purchase a variable life contract and that no variable life contract will [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~]:

(A) - (E) (No change.)

(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 [~~shall~~] 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 [~~shall~~] submit to the commissioner, in addition to any other materials which may be required by this subchapter [~~these sections~~] or any other applicable laws or rules:

(A) - (B) (No change.)

(C) prior to use in this state, the form of any of the reports to contractholders [~~contract holders~~] 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 [~~shall deem~~] 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 [~~shall~~] 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 [~~him or her~~], will [~~shall~~] be subject to disapproval if at any time it is found by the commissioner [~~him or her~~] not to comply with the standards established by these rules.

§3.804. Insurance Contract and Filing Requirements.

The commissioner will [~~shall~~] 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 [~~shall~~]

be filed with the commissioner and approved or exempted, as applicable, by the commissioner [~~him or her~~] prior to delivery or issuance for delivery in this state.

(A) Each variable life contract, rider, endorsement, and application must [~~shall~~] be filed in accordance with Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings [~~§§3.1 - 3.8 of this title (relating to Preparation and Submission of Individual Life Insurance and Annuity Forms)~~]. A flexible premium variable life contract submission must [~~shall~~] 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 [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~], 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 [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~];

(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 [~~shall~~] be provided in conjunction with the contract.

(B) (No change.)

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

(A) Mortality and expense risks must [~~shall~~] be borne by the insurer. The expense charges must [~~shall~~] be subject to the maximums stated in the contract. The charge for mortality must [~~shall~~] be stated in the contract and may [~~shall~~] not exceed a mortality rate for the attained age of the insured in a table specified for the calculation of cash surrender values in [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~]. 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 [~~State Board~~] of Insurance.

(B) For scheduled premium contracts, a minimum death benefit must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be determined at least annually.

(F) The cash surrender value of each variable life contract must [~~shall~~] 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

[~~shall~~] be in [~~a~~] 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 [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~], for a general account contract with such premiums and benefits. The assumed investment rate may [~~shall~~] not exceed the maximum interest rate permitted under [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~]. If the contract does not contain an assumed investment rate, this demonstration must [~~shall~~] be based on a rate not to exceed the maximum interest rate permitted under [~~the~~] Insurance Code Chapter 1105 [~~, Article 3.44a~~]. 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 [~~shall be~~] 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 [~~shall~~] contain at least the following.

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

(i) - (v) (No change.)

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

(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 [~~shall~~] 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 [~~if~~] 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 [~~shall~~] 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) - (II) (No change.)

(C) - (D) (No change.)

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

(i) the assets of such separate account must [~~shall~~] 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 [~~shall~~] be valued at least as often as any contract benefits vary but at least monthly.

(F) (No change.)

(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 [~~shall be~~] considered as representations and not warranties.

(H) - (K) (No change.)

(L) A provision that the contract will [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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) (No change.)

(O) If settlement options are provided,[~~:~~] at least one such option must [~~shall~~] 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 [~~shall~~] include the following:

(i) (No change.)

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

(iii) - (vi) (No change.)

(Q) Premiums or charges for incidental insurance benefits must [~~shall~~] be stated separately.

(R) Any other contract provisions required by this subchapter [~~these sections~~].

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

(T) (No change.)

(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 [~~shall~~] 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 [~~shall~~] 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) (No change.)

(ii) the amount borrowed must [~~shall~~] bear interest at a rate not to exceed that permitted by [~~the~~] Insurance Code Chapter 1110 [~~, Article 3.44c~~];

(iii) any indebtedness must [~~shall~~] be deducted from the proceeds payable on death;

(iv) any indebtedness must [~~shall~~] 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 [~~shall~~] 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) (No change.)

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

(E) (No change.)

(F) The contract loan provisions must [~~shall~~] 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 [~~shall~~] be withdrawn from the separate account and must [~~shall~~] 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) (No change.)

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

(i) - (v) (No change.)

(D) - (F) (No change.)

§3.805. Reserve Liabilities for Variable Life Insurance.

(a) Reserve liabilities for variable life insurance contracts must [~~shall~~] be established under [~~the~~] Insurance Code Chapter 425, Subchapter B [~~, Article 3.28~~], 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 [~~shall~~] 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 [~~shall~~] be maintained in the general account of the insurer and must [~~shall~~] not be less than the greater of the following minimum reserve:

(1) (No change.)

(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 [~~shall~~] not be less than zero and must [~~shall~~] 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 [~~shall~~] not be less than zero and must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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) - (ii) (No change.)

(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 [~~paid-up~~], the payment must [~~shall~~] equal (i) minus (ii) minus (iii). The amounts of the future death benefits referred to in clause (ii) of this paragraph must [~~shall~~] 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 [~~shall~~]

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 [~~shall~~] be maintained in the general account of the insurer and may [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be maintained in the general account, and reserve liabilities for all variable aspects of the variable incidental insurance benefits must [~~shall~~] 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 [~~shall~~] establish one or more separate accounts pursuant to [~~the~~] Insurance Code Chapter 1152 [~~, Article 3.75~~].

(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 [~~shall~~] be in writing and the commissioner has [~~shall have~~] 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 [~~shall~~] not without prior written approval of the commissioner, employ in any material manner any person who:

(i) - (iii) (No change.)

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

(2) Amounts in the separate account. The insurer must [~~shall~~] 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 change.)

(B) The separate account must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] not be changed without first filing such change with the commissioner.

(A) Any change filed pursuant to this paragraph will [~~shall~~] 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 [~~his or her~~] 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 [~~he or she~~] 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) - (B) (No change.)

(C) actuarially determined costs of insurance (tabular costs) and the release of separate account liabilities. The tabular costs of insurance may [~~shall~~] not exceed the mortality rate for the attained age of the insured in the table specified for the calculation of cash surrender values in [~~the~~] Insurance Code Chapter 1105, [~~Article 3.44a.~~] provided [~~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 [~~State Board~~] of Insurance;

(D) - (G) (No change.)

(8) Standards of conduct. Every insurer seeking approval to enter into the variable life insurance business in this state must [~~shall~~] 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 [~~shall be~~] 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 [~~shall satisfy~~] 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 [~~shall~~] also apply to members of any separate account's committee or [~~or~~] other similar body.

(10) Investment advisory services to a separate account. An insurer may [~~shall~~] 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) - (B) (No change.)

(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) - (iv) (No change.)

(D) such investment advisory contract must [~~shall~~] 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 [~~he or she~~] 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 [~~State Board~~] of Insurance or commissioner of insurance will [~~, or matter hereafter arising from an event occurring prior to the time these sections become effective shall~~] be determined in accordance with and governed by [~~§§3.821 - 3.830 of this title (relating to Rules and Regulations for Variable Life Insurance) and by~~] the [~~provisions of other~~] applicable statutes, rules, orders, or interpretations of the Texas Department [~~State Board~~] 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 [~~these sections~~] 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. TDI proposes amendments to Subchapter J under Insurance Code §1106.010 and §36.001.

Insurance Code §1106.010 provides that the Commissioner adopt 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.

CROSS-REFERENCE TO STATUTE. Section 3.909 implements Insurance Code §1106.009.

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 [~~shall either~~] be[~~:~~]

[~~(1)~~] provided within 90 days following lapse of an eligible policy[~~; or~~]

[~~(2) provided to existing policyholders within 90 days after the effective date of the Insurance Code, Article 3.44d, or if this subchapter is not effective on or before 90 days after the effective date of Article 3.44d, no later than February 1, 1996~~].

(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. [~~If this method is elected by the insurer, for policies issued on or after September 1, 1995, but prior to the effective date of this subchapter, the language of §3.913 of this title (relating to Notice and Disclosure Form) shall be incorporated no later than February 1, 1996.~~]

(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 [~~shall~~] 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. TDI proposes amendments to Subchapter K under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 specifies that the Commissioner may adopt rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Subchapter K implements Insurance Code Chapter 425.

TEXT.

§3.1001. Authority.

This subchapter is [~~These sections are~~] prescribed and promulgated in respect to the provisions of [~~the~~] Insurance Code §982.114; Chapter 425, Subchapter B; Chapter 1701; Chapter 404; [~~, Articles 3.25, 3.28, 3.42, 3.55-1,~~] and other applicable provisions.

§3.1002. Purpose.

It is the purpose of this subchapter [~~these sections~~]:

(1) - (2) (No change.)

(3) to clarify the interpretation of Insurance Code Chapter 425, Subchapter B, [~~Article 3.28~~] 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 [~~his~~] discretion, require the data specified in this section from any insurance companies which are subject to this subchapter [~~these sections~~]. 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) - (3) (No change.)

(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 [~~shall~~] 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) - (C) (No change.)

(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 [~~State Board~~] 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) (No change.)

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

SUBCHAPTER L. STRENGTHENED RESERVES PURSUANT TO [~~THE~~] INSURANCE CODE §425.067 [~~, ARTICLE 3.28, §9~~]. 28 TAC §3.1101

STATUTORY AUTHORITY. TDI proposes 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, benefits, or contracts 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.

CROSS-REFERENCE TO STATUTE. Subchapter L implements Insurance Code §425.067.

TEXT.

§3.1101. Strengthened Reserves Pursuant to [~~the~~] Insurance Code §425.067 [~~, Article 3.28, §9~~].

A life insurance company may increase the amount of its reserve liabilities by changing the basis of computation as provided in [~~the~~] Insurance Code §425.067 [~~, Article 3.28, §9~~]. The insurer may establish a higher reserving basis by reporting an increase in reserve in Exhibit 5A [~~8A~~] of its annual statement. Thereafter the insurer must [~~shall~~] continue to report on the higher basis. An insurer may, with the approval of the Texas Department [~~State Board~~] of Insurance, as provided in [~~the~~] Insurance Code §425.067 [~~, Article 3.28, §9~~], adopt a lower standard of valuation, but not lower than the minimum standard provided in [~~the~~] Insurance Code §425.053 [~~, Article 3.28, §3~~].

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

STATUTORY AUTHORITY. TDI proposes 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, dividends, or any other contract terms and conditions for individuals of the same class and 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.

CROSS-REFERENCE TO STATUTE. Section 3.1303 and §3.1304 implement Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057. Section 3.1305 implements Insurance Code §541.057.

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 [~~the~~] 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 [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.[; and]

(2) A [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 [shall] 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 [~~the Staff Actuary Life, State Board~~] of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030, [~~1110 San Jacinto Street~~], Austin, Texas 78711-2030 [~~78786~~]. 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 [~~these sections~~].

(e) Notwithstanding any other provision of this subchapter [~~these sections~~], an insurer may [~~shall~~] 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 [~~the~~] 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 [~~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.[~~; and~~]

(2) A [~~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 [~~shall be~~] considered as the basis for acceptable tables according to subsection (a) of this section:

(1) - (14) (No change.)

(c) The Texas Department [~~State Board~~] 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 [~~Life Actuaries Division, State Board~~] of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030 [~~1110 San Jacinto Boulevard~~], Austin, Texas 78711-2030 [~~78701-1998~~].

(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 [~~shall~~] 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 [~~the~~] Insurance Code §541.057 [~~, Article 21.21, §4(7)(a),~~] 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. TDI proposes 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, dividends, or any other contract terms and conditions for individuals of the same class and 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.

CROSS-REFERENCE TO STATUTE. Section 3.1403 implements Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057. Section 3.1404 implements Insurance Code Chapter 1105, Subchapter B, §§1105.051 - 1105.057 and references Insurance Code §425.067.

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 [~~the~~] 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) - (2) (No change.)

(b) The tables specified in subsection (a) of this section must [~~shall~~] 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 [~~the~~] 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) - (2) (No change.)

(d) The tables specified in subsection (c) of this section must [~~shall~~] 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 [~~these sections~~]. Copies may be obtained by contacting the Texas Department [~~Staff Actuary Life, State Board~~] of Insurance, Life and Health Actuarial, MC-LH-ACT, P.O. Box 12030 [~~1110 San Jacinto Street~~], Austin, Texas 78711-12030 [~~78786~~]. These tables are more particularly identified as follows:

(1) - (6) (No change.)

§3.1404. Conditions.

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

(1) (No change.)

(2) use smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by [~~the~~] Insurance Code §425.068 [~~, Article 3.28, §10~~], 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) (No change.)

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

STATUTORY AUTHORITY. TDI proposes 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 §425.064(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.

CROSS-REFERENCE TO STATUTE. Subchapter Q implements Insurance Code §§425.054 - 425.057.

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 [~~Article 3.28, §2A,~~] and for memoranda in support of such opinion;

(2) - (3) (No change.)

§3.1602. Scope and Applicability.

(a) - (b) (No change.)

(c) This subchapter applies [~~shall be applicable~~] 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 [~~2005 Annual Statement and thereafter~~].

(d) (No change.)

§3.1605. General Requirements.

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

(1) - (2) (No change.)

(b) Appointment of actuary. The company must [~~shall~~] give the commissioner timely written notice of the name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary and must [~~shall~~] 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 [~~shall give~~] the commissioner timely written notice in the event the actuary ceases to be appointed or retained as an appointed actuary or to meet the requirements for a qualified actuary. If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice must [~~shall~~] so state and give the reasons for replacement.

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

(1) [~~shall~~] 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) [~~shall~~] 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 [~~shall~~] be in accordance with paragraphs (1) - (3) of this subsection.

(1) Under authority of Insurance Code §425.054 [~~Article 3.28, §2A~~], the statement of actuarial opinion applies [~~shall apply~~] to all in-force [~~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 [~~Article 3.28, §§6, 7, 10, and 11~~], and other applicable Insurance Code provisions, the company must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] consist of the following paragraphs:

(1) (No change.)

(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) (No change.)

(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 [~~shall~~] retain all pertinent aspects of the language provided in this section.

(1) - (6) (No change.)

(c) (No change.)

(d) Adverse opinions. If the appointed actuary is unable to form an opinion, then he or she must [~~shall~~] refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she must [~~shall~~] 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 [~~shall~~] provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness, or reasonableness, as applicable, of the items. This certification must [~~shall~~] 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, [~~Article 3.28~~] 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 [~~shall~~] be made available. If a company chooses to use this alternative, the standards and conditions in effect on July 1 of a calendar year [~~shall~~] apply to statements for that calendar year[~~,~~] and [~~they shall~~] remain in effect until they are revised or revoked. If no list is available, this alternative is not available.

(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 [~~shall~~] be issued no later than March 31 of the year it is first effective. It will [~~shall~~] remain valid until rescinded or modified by the commissioner. The rescission or modifications must [~~shall~~] be issued no later than March 31 of the year they are first effective. Subsequent to that statement being issued, if a company chooses to use this alternative, the company must [~~shall~~] file a request to do so, along with justification for its use, no later than April 30 of the year of the opinion to be filed. The request will [~~shall~~] 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) [~~clause (ii) of this paragraph~~]) for which the required comparison must [~~shall~~] be provided will be published. If a company chooses to use this alternative, the list in effect on July 1 of a calendar year [~~shall~~] apply to statements for that calendar year[~~,~~] and [~~it shall~~] remain in effect until it is revised or revoked. If no list is available, this alternative is not available.

(ii) If a company desires to use this alternative, the appointed actuary must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] provide detailed disclosure of the specific method and assumptions used in determining the reserves held.

(2) (No change.)

§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 [~~shall~~] be prepared in accordance with and subject to the provisions and qualifications of paragraphs (1) - (5) of this subsection.

(1) In accordance with [~~the~~] Insurance Code §§425.054 - 425.057, the appointed actuary must [~~shall~~] 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 [~~shall~~] be made available for examination by the commissioner upon the commissioner's [~~his or her~~] 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 [~~subchapter~~] (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 [~~subchapter~~] (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 [~~shall~~] be paid by the company but will [~~shall~~] be directed and controlled by the commissioner.

(4) The reviewing actuary will [~~shall~~] have the same status as an examiner for purposes of obtaining data from the company, and the work papers and documentation of the reviewing actuary will [~~shall~~] be retained by the commissioner. The reviewing actuary may [~~shall~~] 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 [~~the~~] Insurance Code §§425.054 - 425.057, the appointed actuary must [~~shall~~] prepare a regulatory asset adequacy issues summary, the contents of which are specified in subsection (c) of this section. Texas domestic companies must [~~shall~~] submit the regulatory asset adequacy issues summary by email to ActuarialDivision@tdi.texas.gov or by paper copy to the [~~Actuarial Division, Financial~~

~~Program, M.C. 302-3A,~~] Texas Department of Insurance, Financial Regulation Division, MC-FRD, P.O. Box 12030 [~~333 Guadalupe, P.O. Box 149104~~], Austin, Texas 78711-2030 [~~78714-9104~~] 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 [~~shall~~] 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 [~~subchapter~~] (relating to Statement of Actuarial Opinion Based on an Asset Adequacy Analysis) is provided, the memorandum must [~~shall~~] demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in §3.1605(c) of this title [~~subchapter~~]and any additional standards under this subchapter. The documentation of the assumptions used in paragraphs (1) and (2) of this subsection must [~~shall~~] be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions. The memorandum must [~~shall~~] specify:

(1) - (2) (No change.)

(3) For the analysis basis:

(A) - (B) (No change.)

(C) rationale for degree of rigor in analyzing different blocks of business (including [~~include in the rationale~~] the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);

(D) criteria for determining asset adequacy (including [~~include in the criteria~~] the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and

(E) (No change.)

(4) - (6) (No change.)

(c) (No change.)

(1) The regulatory asset adequacy issues summary must [~~shall~~] 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 [~~shall~~] be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(B) - (D) (No change.)

(D) comments on any interim results that may be of significant concern to the appointed actuary. For example, the comments must [~~shall~~] 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) - (F) (No change.)

(2) The regulatory asset adequacy issues summary must [~~shall~~] contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and [~~shall~~] be signed and dated by the appointed actuary rendering the actuarial opinion.

(3) (No change.)

(d) Conformity to standards of practice. The memorandum must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be disclosed in the memorandum.

(f) Documentation retention. The appointed actuary must [~~shall~~] retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions, and the results obtained.

SUBCHAPTER R. LIFE SETTLEMENT.
DIVISION 2. LICENSE APPLICATION AND RENEWAL; COURSE AND TRAINING REQUIREMENTS; MAINTENANCE OF RECORDS.
28 TAC §§3.1720

STATUTORY AUTHORITY. TDI proposes 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.

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.

CROSS-REFERENCE TO STATUTE. Section 3.1720 implements Insurance Code §1111A.003(h).

TEXT.

§3.1720. Forms.

(a) - (c) (No change.)

(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% [~~percent~~] 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 [~~obtained from and~~] submitted to the Texas Department of Insurance, Life and Health Division, Filings Intake, MC-LH-LHL, P.O. Box 12030, Austin, Texas 78711-2030 ~~[Company Licensing and Registration, MC 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe St., Austin, Texas 78701~~], 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. TDI proposes 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.

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.

CROSS-REFERENCE TO STATUTE. Section 3.1740 implements Insurance Code §1111A.005(a). Section 3.1742 implements Insurance Code §1111A.012.

TEXT.

§3.1740. Form Filing Requirements and Approval, Disapproval, or Withdrawal of Forms; Fees.

(a) - (b) (No change.)

(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 ~~[Rate and Form Review Office, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe St., Aus~~tin, Texas 78701]. 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 [~~Rate and Form Review Office, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe St., Austin, Texas 78701~~,] 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) - (6) (No change.)

(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) (No change.)

(C) be submitted on 8-1/2-by-11-inch [~~8-1/2-by-11-inch~~] paper or formatted for that size if submitted electronically. The department will not accept bound forms;

(D) - (F) (No change.)

(2) - (3) (No change.)

(f) - (m) (No change.)

(n) Request for hearing. The life settlement broker or provider may make a written request for a hearing to the [~~Chief Clerk, Mail Code 113-2A,~~] Texas Department of

Insurance, Chief Clerk, MC-GC-CCO, P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030 [~~78714-9104 or 333 Guadalupe St., Austin, Texas 78701~~], on receiving notification under subsection (l) of this section of any withdrawal of approval or disapproval of a form by the department.

(o) (No change.)

§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 [~~Rate and Form Review Office, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe St., Austin, Texas 78701~~], 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. TDI proposes 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.

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.

CROSS-REFERENCE TO STATUTE. Section 3.1760 implements Insurance Code §1111A.006.

§3.1760. Reporting Requirements.

(a) (No change.)

(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 [~~Rate and Form Review Office, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe St., Austin, Texas 78701~~], or by accessing the department's website at www.tdi.texas.gov/forms. The report must include the following:

(1) - (3) (No change.)

(c) - (d) (No change.)

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. TDI proposes 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 necessary to implement 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.

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.

CROSS-REFERENCE TO STATUTE. Subchapter S implements Insurance Code Chapter 1201.

TEXT.

§3.3001. Applicability and Scope.

(a) Unless otherwise specified, this subchapter applies [~~these sections apply~~] 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 [~~hereof~~], except they do not apply to[~~:~~] individual [~~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 [~~the~~] Insurance Code Chapter 1153 [~~, Article 3.53~~]. 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 [~~these sections~~] are in addition to any other applicable regulations previously adopted; however, this subchapter governs [~~these sections govern~~] wherein any conflict or difference exists. The provisions of applicable statutes govern where ambiguity or difference exists between this subchapter [~~these sections~~] and such statutes.

§3.3009. Policy Definitions of Sickness.

Except as provided in this subchapter [~~these sections~~], 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 [~~the~~] Insurance Code §1201.208 [~~, Article 3.70-3(A)(2),~~] 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 [~~the~~] Insurance Code §1451.001 [~~, Article 3.70-2(B)~~].

§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 [~~shall~~] be renewed or continued in force at the option of the insured.

(b) (No change.)

(c) Individual hospital, medical or surgical coverage may only be discontinued or nonrenewed based on one or more of the following circumstances:

(1) - (3) (No change.)

(4) in regards only to coverage offered by an issuer under [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], 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) - (g) (No change.)

(h) Nothing in this section may [~~shall~~] 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 [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], 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 [~~Department of~~] Human Services Commission will [~~shall~~] be paid to the Texas Health and Human Services Commission [~~said department~~]" whenever:

(1) the Texas Health and [~~Department of~~] Human Services Commission is paying benefits under [~~the~~] 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) (No change.)

(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 [~~Department of~~] Human Services Commission.

(c) With respect to any policy forms approved by the Texas Department [~~State Board~~] 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 [~~State Board~~] 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 [~~shall~~] include termination provisions that [~~which shall~~] 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 [~~regards~~] to individual hospital, medical or surgical coverage, a policy may [~~shall~~] only contain the following bases for termination of coverage:

(1) (No change.)

(2) in regard [~~regards~~] to policies covering a spouse of the primary insured or dependents:

(A) (No change.)

(B) Coverage of a dependent may terminate upon the dependent's attainment of a limiting age, subject to [~~this section, Article 3.70-2(C),~~] Insurance Code §1201.059 [~~(Form of Policy)~~], 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 [~~shall~~] stipulate that in the event of the insured's death the spouse of the insured, if covered under the policy, will [~~shall~~] become the insured.

(d) The provision must [~~shall~~] 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 [~~shall~~] continue during the period for which an identifiable premium was accepted, except where such acceptance was predicated on a misstatement of age outlined in [~~the~~] Insurance Code §1201.011 [~~, Article 3.70-7~~].

(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 [~~shall~~] provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy continued in force.

(f) The provision must [~~shall~~] stipulate that termination of the policy by the insurer will [~~shall~~] be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured 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) (No change.)

(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) (No change.)

(2) chiefly dependent upon the insured for support and maintenance. Proof of the incapacity and dependency must [~~shall~~] 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) - (b) (No change.)

(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 [~~shall~~] 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 [Policy Approval Section, State Board of Insurance, 1110 San Jacinto Street, Austin, Texas 78786].

(d) (No change.)

(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 [shall] 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 [shall] provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata [pro-rata] basis;

(B) (No change.)

(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 [pro-rata] premium must be refunded.

(2) (No change.)

§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 [~~shall~~] 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 [~~these sections~~]. Such policies must also meet the requirements of [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~]. Nothing in this section will [~~shall~~] preclude the issuance of any policy or contract combining two or more of the categories of coverage as set forth in [~~the~~] Insurance Code §1201.104 [~~, Article 3.70-1(F)(1)(a)-(h)~~].

§3.3092. Format, Content, and Readability for Outline of Coverage.

(a) Format.

(1) Each outline of coverage must [~~shall~~] contain the appropriate text and be in the appropriate format of the outlines of coverage set forth in this subchapter [~~these sections~~] and may not contain any material of an advertising nature, except for the insurer's logotype.

(2) The outline of coverage must [~~shall~~] be plainly printed in light-faced type of a style in general use, the size of which must [~~shall~~] 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 [~~one-point~~] leading.

(3) The contrast and legibility of the color of ink and the color of paper of the outline of coverage must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be stated clearly and concisely, and [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be included. Limitations on coverage for pre-existing conditions that qualify

payment of benefits must [~~shall~~] be summarized. Provisions which reduce benefits otherwise payable due to other coverage must [~~shall~~] be described.

(5) Drafting instructions for paragraph 5. This paragraph must [~~shall~~] 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 [~~shall~~] 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 [~~20~~]: "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 [~~shall~~] be stated. In the event the mode stated is not an exact multiple of the annual

premium, then the annual premium must [~~shall~~] also be stated. Initial policy fees must [~~shall~~] be stated separately. If premiums are "step-rated," they must [~~shall~~] 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 [~~shall~~] also include a statement of the policy grace period.

(c) Readability.

(1) Insurers must [~~shall~~] 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 [~~Minimum Standards and Benefits and Readability for Accident and Health Insurance Policies~~]). 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 [~~shall~~] establish a specific minimum level of readability which may not be more difficult than the equivalent of a ninth-grade [~~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 [~~shall~~] 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 [~~shall~~] file the readability score of the outline of coverage along with the outline of coverage.

(5) This subsection does [~~shall~~] 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. [~~The~~] Insurance Code Chapter 1201, Subchapter E [~~, Article 3.70-3(A)~~], 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 [~~article~~]. The same is true with respect to optional policy provisions as provided in [~~the~~] Insurance Code §§1201.219 - 1201.226 [~~, Article 3.70-3(B)~~]. 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 [~~shall~~] be organized so that it follows a logical sequence.

(b) Coverages must [~~shall~~] be self-contained and independent.

(c) The use of provisions which refer the reader to another section must [~~shall~~] be avoided to the extent possible.

(d) General policy provisions applying to all or several like coverages, such as defined words and terms, must [~~shall~~] 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 [~~shall~~] appear early in the policy format.

(f) Nonessential provisions must [~~shall~~] be eliminated.

(g) Captions must [~~shall~~] be of type size and style to clearly stand out.

(h) Type size and style must [~~shall~~] be legible[~~,~~] and [~~shall~~] comply with the requirements set forth in [~~the~~] Insurance Code §1201.054 [~~, Article 3.70-2(A)(4)~~].

(i) Ample blank space must [~~shall~~] separate the policy provisions.

(j) Ample blank space must [~~shall~~] 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 [~~shall~~] be effective 20 days from the date they are filed with the Office

of the Secretary of State and [~~shall~~] 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 [~~regards~~] to policies issued before December 22, 1997, [~~the effective date of these rules~~] and deemed continuous and not annually renewed pursuant to [~~the~~] Insurance Code §1202.001 [~~, Article 3.70-13~~]:

(1) Such policies will [~~shall~~] 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 [~~the effective date of this subchapter~~].

(2) Such policies will [~~shall~~] not be subject to any other provisions of this subchapter, unless the statutory period of continuity prescribed by Insurance Code §1202.001 [~~Article 3.70-13~~] 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 [~~the effective date of this subchapter~~].

SUBCHAPTER T. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES. 28 TAC §3.3321

STATUTORY AUTHORITY. TDI proposes amendments to Subchapter T under Insurance Code §1652.005 and §36.001.

Insurance Code §1652.005 provides that the Commissioner adopt rules to implement 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.

CROSS-REFERENCE TO STATUTE. Section 3.3321 implements Insurance Code §1652.102.

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 [~~shall~~] 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) - (2) (No change.)

(b) The items set forth in subsection (a) of this section must [~~shall~~] 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 [~~Division~~] and reports of multiple Medicare supplement policies should be made to the Texas Department of Insurance, Consumer

Protection and Services, MC-CO-CPS [~~Division, Mail Code 111-1A, Texas Department of Insurance~~], P.O. Box 12030 [~~149104~~], Austin, Texas 78711-2030 [~~78701-9104~~].

SUBCHAPTER U. NEWBORN CHILDREN COVERAGE.
28 TAC §§3.3401 - 3.3403

STATUTORY AUTHORITY. TDI proposes amendments to Subchapter U under Insurance Code §1367.055 and §36.001.

Insurance Code §1367.055 requires the Commissioner to adopt rules 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.

CROSS-REFERENCE TO STATUTE. Subchapter U implements Insurance Code §1367.003.

TEXT.

§3.3401. Purpose.

The purpose of this subchapter [~~these sections~~] is implementation of [~~the~~] Insurance Code §1367.003 [~~, Article 3.70-2(E)~~], so as to clarify the applicability of §1367.003 [~~subsection E~~] to insurance policies to be issued in the future and to existing policies.

§3.3402. Applicability and Scope.

This subchapter applies [~~These sections apply~~] to all individual or group policies of accident and sickness insurance (including policies issued by companies subject to [~~the~~] Insurance Code[~~,~~] Chapter 842 [~~20~~], 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) - (b) (No change.)

(c) If the policy provides accident and sickness coverage for newborn children, such coverage must [~~shall~~] 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) (No change.)

(e) The initial coverage provided newborn children must [~~shall~~] continue for a period of at least 31 days. The insurer may require that before the coverage continues [~~shall continue~~] 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) [~~The~~] Insurance Code §1367.003 [~~, Article 3.70-2(E),~~] 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 [~~the~~] Insurance Code §1367.003 [~~, Article 3.70-2(E)~~]. With respect to any policy forms approved by the Texas Department [~~State Board~~] of Insurance prior to the effective date of §1367.003 [~~Article 3.70-2(E)~~], an insurer is authorized to achieve compliance with §1367.003 [~~Article 3.70-2(E)~~] by the use of endorsements or riders provided such endorsements or riders are approved by the Texas Department [~~State Board~~] of Insurance as being in compliance with [~~the~~] Insurance Code §1367.003 [~~, Article 3.70-2(E),~~] and other provisions of the Texas Insurance Code.

(g) [~~The~~] Insurance Code §1367.003 [~~, Article 3.70-2(E),~~] 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 [~~shall~~] be said to have been "renewed, extended or amended" for purposes of [~~the~~] Insurance Code §1367.003 [~~, Article 3.70-2(E)~~], and the requirements of §1367.003 will [~~Article 3.70-2(E) shall~~] attach to the policy.

(h) [~~The~~] Insurance Code §1367.003 [~~, Article 3.70-2(E),~~] 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 [~~shall~~] be considered "renewed, extended or amended" upon the expiration of any applicable collective bargaining agreement.

(i) Nothing in this subchapter will [~~these sections shall~~] be deemed to extend the provisions of [~~the~~] Insurance Code §1367.003 [~~, Article 3.70-2(E),~~] 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, 3.3849, 3.3871, 3.3873, and 3.3874

STATUTORY AUTHORITY. TDI proposes amendments to Subchapter Y, Division 2, under Insurance Code §1651.107 and §36.001.

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.

CROSS-REFERENCE TO STATUTE. Subchapter Y, Division 2, implements Insurance Code §1651.051 and §1651.005.

TEXT.

§3.3829. Required Disclosures.

(a) Required disclosure [~~Disclosure~~] of policy provisions [~~Policy Provisions~~].

(1) Long-term care insurance policies and certificates must [~~shall~~] contain a renewability provision as required by §3.3822 of this title [~~subchapter~~] (relating to Minimum Standard for Renewability of Long-term Care Coverage). Such provision must [~~shall~~] be appropriately captioned, [~~shall~~] appear on the first page of the policy, and [~~shall~~] clearly state the duration, where limited, of renewability and the duration of the 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, [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] appear as a separate paragraph of the policy or certificate and [~~shall~~] be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants [~~shall~~] 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 [~~shall~~] have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has [~~shall 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.

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in [~~the~~] Insurance Code Chapter 1651 or §3.3824 of this title [~~subchapter~~] (relating to Preexisting Conditions Provisions) must [~~shall~~] set forth a description of such limitations or conditions in a separate

paragraph of the policy or certificate and [~~shall~~] label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates must [~~shall~~] appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates must [~~shall~~] contain a claim denial provision which is [~~shall be~~] appropriately captioned. Such provision must [~~shall~~] clearly state that if a claim is denied, the insurer will [~~shall~~] 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 [~~subchapter~~] (relating to Standards for Eligibility for Benefits) must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~Disclosure~~] of rating practices [~~Rating Practices~~].

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices set forth in paragraph (2) of this subsection [~~shall~~] 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 [~~shall~~] apply on the policy anniversary following January 1, 2003.

(2) Insurers must [~~shall~~] 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 [~~shall~~] be provided at the time of delivery of the policy or certificate:

(A) - (C) (No change.)

(D) a general explanation for applying premium rate or rate schedule adjustments that includes [~~shall include~~]:

(i) - (ii) (No change.)

(E) (No change.)

(3) - (4) (No change.)

(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 [~~shall~~] 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 [~~shall~~] make all disclosures required by paragraphs (2)(E), (3), (4), and (5) of this subsection.

(7) An applicant must [~~shall~~] 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 [~~shall~~] sign no later than at the time of delivery of the policy or certificate.

(8) An insurer must [~~shall~~] 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) - (E) (No change.)

(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 [~~Filings Intake Division~~, ~~Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texa~~s, ~~78714-9104 or 333 Guadalupe, Austin, Texas,~~ 78701].

(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 [~~Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 33~~3 ~~Guadalupe, Austin, Texas 78701~~], or by accessing the department's website at www.tdi.texas.gov/forms [~~www.tdi.state.tx.us~~].

(H) - (I) (No change.)

(9) An insurer must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

(c) Effective dates [~~Dates~~] for use [~~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) - (4) (No change.)

§3.3832. Outline of Coverage.

(a) An outline of coverage must [~~shall~~] 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 [~~shall~~] be delivered prior to the presentation of an application or enrollment form. In the case of direct-response solicitations, the outline of coverage must [~~shall~~] be delivered in conjunction with any application or enrollment form. The outline of coverage must [~~shall~~] comply with the following standards and standard format. The contents of the outline of coverage must [~~shall~~] include the following prescribed text.

(1) The outline of coverage must [~~shall~~] be a freestanding document, in no smaller than 12-point type.

(2) The outline of coverage must [~~shall~~] contain no material of an advertising nature.

(3) Text which is capitalized in the standard format outline of coverage must [~~shall~~] 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) (No change.)

(b) The outline of coverage must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be stated. Initial policy fees must [~~shall~~] 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 [~~shall~~] include a statement of the policy grace period.)

(12) TEXAS DEPARTMENT OF INSURANCE'S CONSUMER HELP LINE. An insurer must [~~shall~~] 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 [~~Department of Aging~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] be provided.

(B) A disclosure of any expected premium increases or additional premiums to pay for automatic or optional benefit increases must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~unintentional lapse and reinstatement~~]).

§3.3837. Reporting Requirements.

(a) Policy or certificate replacements [~~Certificate Replacements~~] and lapses [~~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 [~~shall~~] 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) (No change.)

(2) Reporting of 10 percent of agents. Each insurer must [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(a)(2) (No change.)

(3) Reporting number of lapsed long-term care policies. Each insurer must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(b) (No change.)

(c) Claims denied [~~Denied~~] by class of business [~~Class of Business~~].

(1) Definitions. For purposes of this subsection, the following terms [~~shall~~] have the following meanings.

(A) - (B) (No change.)

(2) Report of claims denied [~~Claims Denied~~]. Each insurer issuing long-term care insurance benefits in this state must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(c)(2) (No change.)

(d) Long-Term Care Partnership Program. Each insurer that markets partnership policies in this state must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

(e) Data report [~~Report~~] for non-partnership plans [~~Non-Partnership Plans~~]. Each insurer that markets long-term care insurance in this state must [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

Figure: 28 TAC §3.3837(e) (No change.)

(f) Suitability data [~~Data~~]. Each insurer issuing long-term care benefits in this state must [~~shall~~] 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 [~~shall~~] submit the required information electronically in a format prescribed by the department on the department's website.

(1) Reporting form [~~Form~~]. A representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form is as follows:

Figure: 28 TAC §3.3837(f)(1) (No change.)

(2) Applicability.

(A) This subsection applies [~~shall apply~~] to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(B) This subsection does [~~shall~~] not apply to life insurance policies:

(i) - (iii) (No change.)

(g) Demonstration of compliance with applicable loss ratio standards. Each insurer must [~~shall~~] file by June 30 of each year the annual rate filing required by [~~the~~] 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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~]. Such demonstration must ~~[shall]~~ be in addition to any demonstration required under §3.3831(c)(2)(B) - (D) of this title [~~subchapter~~] (relating to Standards and Rates) and must ~~[shall]~~ include the following information by calendar duration, separately by form number:

(1) - (7) (No change.)

§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 [~~shall~~] 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 [~~shall~~]:

(1) - (3) (No change.)

(c) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer must [~~shall~~] develop procedures that take the following factors into consideration:

(1) - (3) (No change.)

(d) The issuer and, where an agent is involved, the agent, must [~~shall~~] make reasonable efforts to obtain the information set forth in subsection (c) of this section. The

efforts must [~~shall~~] 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) - (2) (No change.)

(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 [~~Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 14904, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texa~~s, 78701].

(e) - (f) (No change.)

(g) The issuer must [~~shall~~] 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) (No change.)

(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) - (5) (No change.)

(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 [~~Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~].

(7) (No change.)

(j) (No change.)

Figure: 28 TAC §3.3842(j) (No change.)

(1) - (4) (No change.)

(k) This section and the delivery requirements for the shopper's guide in §3.3840 of this title [~~subchapter~~] (relating to Requirements To [~~to~~] Deliver Shopper's Guide) [~~shall~~] 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 [~~subchapter shall~~] not apply to life insurance policies:

(1) - (3) (No change.)

§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 [~~Requirements~~].

(1) Any insurer issuing long-term care insurance to an association, as defined in the Insurance Code §1251.052, must [~~shall~~] 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) - (C) (No change.)

(2) (No change.)

(b) Advertisements. Advertisements for long-term care insurance must be filed with the department in accordance with §3.3838(1) of this title [~~subchapter~~] (relating to Filing Requirements for Advertising).

(c) Association disclosure requirements [~~Disclosure Requirements~~].

(1) (No change.)

(2) If the association and the insurer have interlocking directorates or trustee arrangements, the association must [~~shall~~] disclose that fact to its members.

(d) Board approval requirements [~~Approval Requirements~~]. The board of directors of associations selling or endorsing long-term care insurance policies or certificates must [~~shall~~] review and approve the insurance policies and certificates as well as the compensation arrangements made with the insurer.

(e) Insurer certification form [~~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) - (C) (No change.)

(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 [~~Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~].

(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 [~~Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas~~ 78701], or from the department's website at ~~www.tdi.texas.gov/~~forms [www.tdi.state.tx.us].

(F) (No change.)

Figure: 28 TAC §3.3849(e)(1)(F) (No change.)

(2) The initial certification must [~~shall~~] be submitted to the department between January 1, 2010, and January 31, 2010, for the calendar year 2009, and thereafter must [~~shall~~] 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 [~~chapter~~] (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 [Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701].

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. TDI proposes 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, relating to the partnership for long-term care program.

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.

CROSS-REFERENCE TO STATUTE. Subchapter Y, Division 4, implements Insurance Code §1651.051.

§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 [~~subchapter~~] (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) (No change.)

(B) the policy is intended to be a qualified long-term care insurance policy under the provisions of §3.3847 of this title [~~subchapter~~] (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 [~~subchapter~~] (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) based on the insured's then attained age;

(D) (No change.)

(2) Required disclosure notice.

(A) A policy or certificate represented or marketed as a long-term care partnership policy or certificate must [~~shall~~] 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) - (v) (No change.)

(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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin,~~ Texas 78701].

(vii) - (x) (No change.)

(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 [~~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 [~~shall~~] 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 [~~shall~~] include but not be limited to the following:

(1) - (3) (No change.)

§3.3873. Filing Requirements for Long-Term Care Partnership Policies.

(a) Prior approval requirements [~~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) (No change.)

(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) - (C) (No change.)

(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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~].

(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 [~~Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701~~], or from the department's website at www.tdi.texas.gov/forms [~~www.tdi.state.tx.us~~].

(F) (No change.)

(b) Policies not previously approved [~~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) - (3) (No change.)

(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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas~~, 78701].

(c) Previously approved policies [~~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) - (5) (No change.)

(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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texa~~s, 78701].

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates.

(a) Insurer training verification [~~Training Verification~~] and certification requirements [~~Certification Requirements~~] for agents [~~Agents~~]. The following requirements apply to an insurer that is offering partnership policies or certificates in this state.

(1) - (3) (No change.)

(b) Agent training certification form requirements [~~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) - (3) (No change.)

(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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701~~].

(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 ~~[Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701]~~, or from the department's website at www.tdi.texas~~.gov/forms~~ ~~[www.td~~i.state.tx.us].

(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) - (B) (No change.)

(c) Agent training certification filing requirements [~~Training Certification Filing Requirements~~]. An insurer offering partnership policies or certificates in this state must [~~shall~~] 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 [~~shall~~] 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) (No change.)

(2) Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) of this title [~~chapter~~] (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 ~~[Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701]~~.

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. TDI proposes amendments to Subchapter Z under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 specifies that the Commissioner may adopt rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Subchapter Z implements Insurance Code §1701.005(b).

TEXT.

§3.4001. Purpose.

The purpose of this subchapter [~~these sections~~] is to exempt certain life and accident and sickness policy forms and annuity contract forms from certain of the

requirements of [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~]. Chapter 1701 [~~Article 3.42~~] 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 [~~State Board~~] of Insurance as provided in §1701.054 [~~Article 3.42, §(d)~~]. Insurance Code §1701.005(b) [~~Article 3.42, §(f),~~] provides for exemption by the commissioner [~~board~~] of policy forms from the requirements of Chapter 1701 [~~Article 3.42~~] under certain circumstances. This subchapter exempts [~~These sections exempt~~] the forms specified from the requirement that they either be approved before being used or reviewed after being used as provided in §1701.054 [~~Article 3.42, §(d)(1)~~]. However, this subchapter does [~~these sections do~~] not exempt such forms from the requirement that they be filed before being used. An additional purpose of this subchapter [~~the sections~~] is to expedite the review process of forms filed under [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~].

§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 [~~forms~~], rider, or endorsement forms not specifically exempted by this subchapter [~~these sections~~], must be filed to be reviewed and approved in accordance with [~~the~~] Insurance Code §1701.051 and §1701.054 [~~, Article 3.42, §(d)~~].

§3.4004. Exempt Forms.

(a) Group and individual life forms [~~Individual Life Forms~~]. The group and individual life insurance forms specified in this subsection are exempt from the review and approval requirements of [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~], 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 [~~the~~] Insurance Code §§1131.003, 1131.051 - 1131.058, 1131.060, and 1131.064(b) [~~Article 3.50, §1(1), (2), (3), (4), (5), (6)(b), (7), (7A), (8), (9), and (10)~~], listed in subparagraphs (A) and (B) of this paragraph:

(A) - (B) (No change.)

(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 [~~, Article 3.50, §1(5)~~];

(3) - (6) (No change.)

(b) Exceptions. The provisions of subsection (a)(1) and (2) of this section do [~~shall~~] 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) - (7) (No change.)

(8) forms subject to [~~the~~] Insurance Code Chapter 1153 [~~, article 3.53~~];

(9) - (11) (No change.)

(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 [~~Article 3.50, §1(6)(a)~~], relating to discretionary groups.

(c) Group and individual annuity forms [~~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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~], 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) - (2) (No change.)

(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) (No change.)

(B) for purposes of this paragraph, and paragraph (4) of this subsection, "two-tier [~~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) - (7) (No change.)

(d) Exceptions. The provisions of subsection (c) of this section do [~~shall~~] not include any of the following annuity forms:

(1) - (2) (No change.)

(3) annuities that contain an equity indexed provision, long-term care or other accident- [~~accident~~] and health-related [~~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- [~~accident~~] and health-related [~~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 [~~Article 3.50, §1(6)(a)~~], relating to discretionary groups.

(e) Group and individual accident and health forms [~~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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~], 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 [~~the~~] Insurance Code §1251.051 and §1251.052 [~~, Article 3.51-6, §1(a)(1) and (2)~~]; provided the forms issued under authority of [~~the~~] Insurance Code §1251.052 [~~, Article 3.51-6, §1(a)(2),~~] 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 [~~the~~] Insurance Code §§1251.351 - 1251.358 [~~, Article 3.51-6, §2(a)(1)-(8)~~];

(C) any group master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of [~~the~~] Insurance Code §§1251.051, 1251.052, or 1251.053 [~~, Article 3.51-6, §1(a)(1), (2), or (3)~~] 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 [~~the~~] Insurance Code §1251.051 and §1251.052 [~~, Article 3.51-6, §1(a)(1) or (2)~~] providing long-term [~~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) (No change.)

(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 [~~, Article 3.51-6, §1(a)(3)~~].

(f) Exceptions. The provisions of subsection (e) of this section do [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] not apply to any Medicare supplement policies as defined in [~~the~~] Insurance Code Chapter 1652 [~~, Article 3.74~~], 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 [~~shall~~] not apply to any long-term [~~long-term~~] care policies as defined in [~~the~~] Insurance Code Chapter 1651 [~~, Article 3.70-12~~] (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 [~~shall~~] 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 [~~shall~~] not apply to any group forms which are issued under the authority of Insurance Code §1251.056 [~~, Article 3.51-6, §1(a)(6)~~] (discretionary groups).

(6) The provisions of subsection (e)(2)(H) of this section do [~~shall~~] 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 [~~Previously Approved Forms~~]. Any form not otherwise exempted under this subchapter [~~these sections~~] that is an exact copy of a previously approved form is exempt from the review and approval requirements of [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~]. 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 [~~Filing of Policy Forms, Riders, Amendments and Endorsements for Life, Accident and Health Insurance and Annuities~~]). 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 [~~Article 3.42(c)~~], as well as for corrections, resubmissions, substitutions, and filings for forms exempted from review and official action by this subchapter [~~these sections~~]. Form "TEXAS POLICY FORM CERTIFICATIONS" is available from the Life and Health Division [~~Life/Health Group~~], has been filed with the Texas Register Division of the Secretary of State for public inspection, and is adopted by reference in this subchapter [~~these sections~~]. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating [~~Relating~~] to Appendix).

(h) Copies of previously approved forms subsequently submitted in foreign language (non-English) [~~Previously Approved Forms Subsequently Submitted in Foreign Language (Non-English)~~]. Any form not otherwise exempted under this subchapter [~~these sections~~] 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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~]. 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) (No change.)

(b) Insurers must [~~shall~~] 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) - (4) (No change.)

(c) Every filing exempted from review by this subchapter must [~~these sections shall~~] 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 [~~Article 3.42(c)~~], 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 [~~Life/Health Group~~], has been filed with the *Texas Register* Division of the Secretary of State for public inspection, and is adopted by reference in this subchapter [~~these sections~~]. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating [~~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 [~~Requirements for Filing of Policy Forms, Riders, Amendments and Endorsements for Life, Accident and Health Insurance and Annuities~~]).

(3) (No change.)

SUBCHAPTER AA. LIMITED EXEMPTION FOR INSURANCE COVERAGE FROM THE REQUIREMENTS OF [~~THE~~] INSURANCE CODE CHAPTER 1701 [~~, ARTICLE 3.42~~]. 28 TAC §§3.4101 - 3.4103 and 3.4105

STATUTORY AUTHORITY. TDI proposes amendments to Subchapter AA under Insurance Code §1701.060 and §36.001.

Insurance Code §1701.060 specifies that the Commissioner may adopt rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Subchapter AA implements Insurance Code §1701.055.

TEXT.

§3.4101. Purpose.

This subchapter provides [~~These sections provide~~] for exempting certain contracts or coverage from the requirement in [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42,~~] that such contracts or coverage be filed for review with the Texas Department [~~State Board~~] 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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~], 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 [~~these sections~~]. The department [~~board~~] 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 [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42,~~] that such forms be filed for review with the Texas Department [~~State Board~~] 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 [~~the~~] Insurance Code §§1131.051, 1131.052, 1251.051, and 1251.052 [~~Article 3.50, §1(1) and (2), and Article 3.51-6, §1(a)(1) and (2)~~], insofar as it applies to a labor union as group policyholder if the coverage conforms to the following:

(A) - (B) (No change.)

(C) it is the subject of aggressive and knowledgeable bargaining in a fully arms-length fashion on the part of the policyholder [~~policy holder~~]; and

(D) (No change.)

(2) group life or accident or health insurance coverage delivered or issued for delivery to the groups authorized by [~~the~~] Insurance Code §1131.060 and §1251.052 [~~, Article 3.50, §1(10), and Article 3.51-6, §1(a)(2)~~], if the coverage conforms to the following:

(A) - (D) (No change.)

§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 [~~State Board~~] 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 [~~State Board~~] 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 [~~State Board~~] of Insurance by the later of:

(i) - (ii) (No change.)

(D) the insurer must submit the exempted forms for review with the Texas Department [~~State Board~~] of Insurance in the usual manner prescribed by [~~the~~] Insurance Code Chapter 1701 [~~, Article 3.42~~], as soon as possible after:

(i) - (ii) (No change.)

(2) (No change.)

§3.4105. Disciplinary Measures.

The Texas Department [~~State Board~~] of Insurance may at any time revoke the exemption specified in this subchapter [~~these sections~~] on the grounds that a company:

(1) has not complied with this subchapter [~~these sections~~]; or

(2) by failing to abide by other applicable law is found to be unworthy of the exemption. The department [~~board~~] may, after hearing, revoke that company's right to future exemptions under this subchapter [~~these sections~~] 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. TDI proposes 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 specifies that the Commissioner may adopt rules necessary to implement the purpose 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.

CROSS-REFERENCE TO STATUTE. Section 3.4317 implements Insurance Code §1111.052.

TEXT.

§3.4317. Effective Date [~~; Grace Period~~].

This [~~(a) Except as otherwise provided in subsection (b) of this section, this~~] subchapter, as adopted by the commissioner, applies [~~shall apply~~] 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 [~~shall~~] be 20 days after the date the adopted subchapter is filed with the Office of the Secretary of State.

[~~(b) A life insurance contract meeting the requirements of §3.129 of this title (relating to Acceleration of Life Insurance Benefits), as effective until the effective date of this subchapter, and the Insurance Code, Article 3.50-6, as amended effective September 1, 1997, may continue to be marketed, delivered, issued for delivery, or renewed in this state during a grace period lasting 90 days after the effective date of this subchapter. An insurer delivering, issuing for delivery or renewing such a life insurance contract during the grace period shall, at the option of the insured, replace the contract with a contract meeting the requirements of this subchapter at the next renewal date of the contract, without regard to the health status or medical history of the insured and without raising the insured's premium based solely on the replacement.~~]

SUBCHAPTER EE. VALUATION OF LIFE INSURANCE POLICIES.
28 TAC §3.4503 and §3.4506

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 3.4506 implements Insurance Code §425.058(c)(3).

TEXT.

§3.4503. Applicability.

This subchapter applies [~~shall apply~~] to all life insurance policies, with or without nonforfeiture values, issued on or after January 1, 2000, and before January 1, 2017 [~~the effective date of this subchapter~~], 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) - (2) (No change.)

§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 [~~Reserves~~]. Basic reserves must [~~shall~~] be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy 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) - (2) (No change.)

(b) Deficiency reserves [~~Reserves~~].

(1) The deficiency reserve at any duration must [~~shall~~] be calculated:

(A) - (C) (No change.)

(2) This subsection applies [~~shall apply~~] to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality specified in §3.4505(b) of this title (relating [~~Relating~~] to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves) and rate of interest.

(3) Deficiency reserves, if any, must [~~shall~~] be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated in §3.4505(b) of this title (relating [~~Relating~~] to General Calculation Requirements for Basic Reserves and Premium Deficiency Reserves).

(4) (No change.)

(c) Minimum value [~~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 [~~shall~~] be the ten-year select factors incorporated into Insurance Code Chapter 425, Subchapter B [~~, Art 3.28~~]. 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 [~~Pattern~~] of guaranteed cash surrender values [~~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 [~~shall~~] not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.

(2) The reserves actually held subsequent to any unusual guaranteed cash surrender value must [~~shall~~] not be less than the reserves calculated by treating the policy as an n year policy providing term insurance plus a pure endowment equal to the next unusual guaranteed cash surrender value, and treating any unusual guaranteed cash surrender value at the end of the prior segment as a net single premium, where:

(A) - (C) (No change.)

(e) Optional exemption [~~Exemption~~] for yearly renewable term [~~Yearly Renewable Term~~] (YRT) reinsurance [~~Reinsurance~~]. At the option of the company, the following approach for reserves on YRT reinsurance may be used:

(1) (No change.)

(2) Basic reserves must [~~shall~~] 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) (No change.)

(B) Deficiency reserves must [~~shall~~] 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) (No change.)

(5) A reinsurance agreement will [~~shall~~] 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 [~~shall~~] be limited to the amount of reserve held by the assuming company for the affected policies.

(f) Optional exemption [~~Exemption~~] for attained-age-based yearly renewable term life insurance policies [~~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) (No change.)

(2) Basic reserves may [~~shall~~] 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) (No change.)

(B) Deficiency reserves may [~~shall~~] 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) (No change.)

(5) A policy will [~~shall~~] be considered an attained-age-based YRT life insurance policy for purposes of this subsection if:

(A) - (B) (No change.)

(6) - (7) (No change.)

(g) Exemption from unitary reserves for certain n-year renewable term life insurance policies [~~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) - (3) (No change.)

(h) Exemption from unitary reserves for certain juvenile policies [~~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) - (3) (No change.)

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE.
DIVISION 1. GENERAL PROVISIONS.
28 TAC §3.5002

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 3.5002 implements Insurance Code Chapter 1153.

TEXT.

§3.5002. Definitions.

The following words and terms, when used in this chapter, [~~shall~~] have the following meanings unless the context clearly indicates otherwise.

(1) - (5) (No change.)

(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 [~~subchapter~~] (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) - (8) (No change.)

(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 subchapter. The insurer must [~~shall~~] 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) (No change.)

(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 [~~subchapter~~] (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 [~~Texas Department of Insurance, Filings Intake Division, MC 106-1E, P.O. Box 149104, Austin, Texas 78714-9104~~]. The forms can also be obtained from the department's internet website [~~web site~~] at www.tdi.texas.gov/forms [~~www.tdi.state.tx.us~~].

(12) - (20) (No change.)

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE. DIVISION 2 APPLICATIONS AND POLICIES. 28 TAC §3.5103

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 3.5103 implements Insurance Code §1153.052.

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 [~~shall~~], in addition to the other requirements of law, set forth:

(1) - (4) (No change.)

(5) the effective date of insurance, and the termination date of insurance. The termination date may [~~shall~~] 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 [~~shall~~] be set forth;

(6) - (7) (No change.)

(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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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, [~~Texas Civil Statutes, Article 5069, Chapters 3-6, 6A, 7, and 15,~~] a refund must be made, except that no cash refund will [~~shall~~] 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. TDI proposes amendments to Subchapter FF, Division 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.

CROSS-REFERENCE TO STATUTE. Section 3.5302 implements Insurance Code Chapter 1153.

TEXT.

§3.5302. Joint Credit Life Insurance.

(a) Joint lives, for purposes of credit life insurance written under [~~the~~] Insurance Code Chapter 1153 [~~, Article 3.53~~], 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 [~~shall~~] not be written covering more than two lives. Jointly indebted persons may [~~shall~~] not both be covered separately at single life rates.

(b) (No change.)

SUBCHAPTER FF. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE.
DIVISION 6. DEVIATION PROCEDURES.
28 TAC §3.5602 and §3.5610

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 3.5602 and §3.5610 implement Insurance Code §1153.105 and §1153.106.

TEXT.

§3.5602. Request for an Approved Deviated Premium Rate.

A request for an approved deviated rate must be made in writing and must [~~shall~~] 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 [~~shall~~] 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 [~~Texas Department of Insurance, Filings Intake Division, MC 106-1E, P.O. Box 149104, Austin, Texas 787~~14-9104]. The form can also be obtained from the department's ~~internet~~ website [web site] at www.tdi.texas.gov/forms [www.tdi.state.tx.us]. 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 [~~shall~~] be made in the presumptive premium rates under these deviation

procedures; except that nothing herein may [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] 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 [~~shall~~] also file a schedule of new case rates as determined by this section.

(d) Approved deviation request form [~~Deviation Request Form~~]. As required by §3.5602 of this title, any request for approved deviated rates must [~~shall~~] 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 [~~Texas Department of Insurance, Filings Intake Division, MC 106-1E, P.O. Box 149104, Austin, Texas 78714-9104~~]. The form can also be

obtained from the department's internet website [~~web site~~] at www.tdi.texas.gov/forms [~~www.tdi.state.tx.us~~].

SUBCHAPTER JJ. 2001 CSO MORTALITY TABLE.
28 TAC §§3.9101, 3.9103, 3.9104, and 3.9106

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Subchapter JJ implements Insurance Code Chapter 425, Subchapter B, §§425.051 - 425.077 and §1105.055.

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) [~~Articles 3.28 §3(a)(iii)~~] and §1105.055(h) [~~3.44a §(8)(e)(6)~~] 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) [~~Articles 3.28 §3(a)(iii)~~] and §1105.055(h) [~~3.44a §(8)(e)(6)~~] 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 [~~shall~~] do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table must [~~shall~~] 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 [~~chapter~~] (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 [~~chapter~~] (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) (No change.)

(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 [~~Actuarial Division, Texas Department of Insurance, 333 Guadalupe, Austin,~~ Texas] or on the internet by accessing the department's website at www.tdi.texas.gov/reports/life/ficso.html [~~www.tdi.state.tx.us/company/~~ficso.html].

§3.9104. Conditions.

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

(1) (No change.)

(2) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by Insurance Code §425.068, [~~Article 3.28 §10~~] and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values, and amounts of paid-up nonforfeiture benefits; or

(3) (No change.)

(b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables must [~~shall~~] be used.

(c) (No change.)

§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 [~~Actuarial Division, Texas Department of Insurance, 333 Guadalupe, Austin, Texas~~] or on the internet by accessing the department's website at www.tdi.texas.gov/reports/life/ficso.html [~~www.tdi.state.tx.us/company/ficso.html~~].

(c) It is [~~shall~~] not, in and of itself, [~~be~~] a violation of Insurance Code Chapter 541 [~~Article 21.21~~] 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. TDI proposes the 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 authorizes the Commissioner to 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 may be accomplished through an exclusive provider organization.

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 CHIP program.

CROSS-REFERENCE TO STATUTE. Subchapter KK implements Insurance Code §845.004 and Government Code §553.0025.

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) - (6) (No change.)

(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 [~~Art. 21.52~~]) 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) (No change.)

(10) Independent review organization--An entity that is certified by the commissioner to conduct independent review under the authority of Insurance Code Chapter 4202 [~~Article 21.58C~~].

(11) - (18) (No change.)

(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) (No change.)

(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 [~~shall~~] not include elective requests for clarification of coverage.

§3.9203. Policy and Premium Rates.

(a) Disclosure of complaint system [~~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 [~~Necessary Covered Services~~]. If medically necessary covered services are not available through exclusive providers, the issuer, on the request of an exclusive provider, must [~~shall~~] allow referral within a reasonable period to a non-network health care provider and must [~~shall~~] 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 [~~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) - (2) (No change.)

(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 [~~that~~] 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) (No change.)

§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 [~~professionally-recognized~~] standards of medical practice. These procedures must include:

(1) - (2) (No change.)

(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 [~~shall~~] be made available to the commissioner;

(4) - (5) (No change.)

(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 [~~article~~]; and

(7) (No change.)

(b) An issuer must [~~shall~~] establish a mechanism for utilizing independent review organizations as outlined in Insurance Code Chapter 4201 [~~Article 21.58A~~].

§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 [~~www.tdi.state.tx.us~~] or 1-800-252-3439.

§3.9212. Appeal of Non-Medicaid Adverse Determinations.

An issuer must [~~shall~~] perform utilization review in compliance with Insurance Code Chapter 4201 [~~Article 21.58A~~] and must maintain procedures for notification, review, and appeal of an adverse determination, as defined by this section. An issuer must [~~shall~~] 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. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Subchapter MM implements Insurance Code §425.058.

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 [~~Article 3.28, §3(a)(iii) (~~] §425.058(c)(3) [~~effective April 1, 2007)~~] and §3.4505 of this title (relating to General Calculation Requirements [~~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 [~~Issued On~~] or after [~~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 [~~Issued On~~] or after [~~After~~] May 1, 2003, and prior [~~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 [~~subchapter~~] (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 [~~Make Election~~]. No election in subsection (a) or (b) of this section may [~~shall~~] be made until the insurer demonstrates that at least 20% [~~percent~~] 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 [~~chapter~~] (relating to 2001 CSO Mortality Table).

(e) Adoption by reference [~~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 [~~Actuarial Division, Texas Department of Insurance, Mail Code 302-3A, P.O. Box 149104, Austin, Texas 78714-9104~~] or on the internet by accessing

the department's [~~Department's~~] website at www.tdi.texas.gov/reports/life/ficso.html [~~www.tdi.state.tx.us/company/ficso.html~~].

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

STATUTORY AUTHORITY. TDI proposes 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.

CROSS-REFERENCE TO STATUTE. Section 3.9503 implements Insurance Code §1114.006.

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 [~~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 [~~subchapter~~] (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 [~~shall~~] 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) - (d) (No change.)

(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 [~~Life, Health & Licensing Division, MC 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin. Texas 78701~~], or by accessing the department website at www.tdi.texas.gov/forms [~~www.tdi.state.tx.us~~].

CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's authority to adopt.

Issued in Austin, Texas on October 14, 2021.

DocuSigned by:
Allison Eberhart
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Allison Eberhart, Deputy General Counsel
Texas Department of Insurance