

**Chapter 3. Life, Accident, and Health Insurance Annuities**

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Related to Such Filings  
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**TEXT.**

**Division 1. Applicability, Scope, Severability, and Definitions.**  
**28 TAC §3.1 and §3.2**

**§3.1. Applicability, Scope, and Severability.**

(a) This subchapter applies to all filings related to an annuity, life insurance, life settlement, credit insurance, accident and health insurance, HMO, or point-of-service product subject to filing with the department, including the following filing types:

(1) a form filing submitted under Insurance Code §1111A.005, concerning Requirements for Contract Forms, Disclosure Forms, and Advertisements; Insurance Code §1153.051, concerning Filing of Form; Insurance Code §1271.101, concerning Approval of Form of Evidence of Coverage or Group Contract; or Insurance Code Chapter 1701, concerning Policy Forms, including:

(A) a policy, contract, group agreement, certificate, evidence of coverage, application, enrollment form, rider, amendment or endorsement, insert page, matrix filing, or limited partial refiling; or

(B) any other coverage document attached to or made part of a contract;

(2) a rate filing submitted in connection with a form filing under this subsection or otherwise required to be filed under Division 5 of this subchapter (relating to Actuarial Filing Requirements), including a schedule of charges, actuarial memorandum, change to rating methodology, or limited partial refiling that includes a change to nonforfeiture values or guaranteed interest rates;

(3) an advertising filing submitted in connection with a product filed under this subchapter, including filings identified under §21.120 of this title (relating to Filing for Review);

(4) a network filing submitted in connection with an HMO, preferred provider benefit plan, exclusive provider benefit plan, or Medicare Select plan, including:

(A) provider contract forms (including a template, executed contract, amendment, termination, or attestation of compliance), delegated entity contracts (including a template, executed contract, amendment, or termination) forms, and related filings;

(B) provider directories;

(C) network configuration filings, including:

(i) new applications;

(ii) limited provider networks;

(iii) annual network adequacy report filings;

(iv) access plans;

(v) service area expansions or reductions; and

(vi) material modification to a network configuration;

(D) notices, including a notice of a network termination or an annual application period for physicians and providers to contract; and

(E) quality assurance program filings;

(5) a group eligibility filing, including articles of incorporation, bylaws, constitution, or a trust agreement, and any other documentation needed to demonstrate that a prospective group or blanket policyholder is eligible under Insurance Code Chapter 1131, Subchapter B, concerning Group and Wholesale, Franchise, or Employee Life Insurance: Eligible Policyholders; Insurance Code Chapter 1251, Subchapter B, concerning Group Accident and Health Insurance: Eligible Policyholders; or Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders;

(6) an informational filing, other than a form filing, rate filing, advertising filing, network filing, or group eligibility filing, that may be subject to review for compliance with Texas law but is not subject to approval, including:

(A) a disclosure, outline of coverage, or a similar plan summary;

(B) notices, including those relating to a discontinuance, withdrawal, uniform benefit modification, and modification of drug coverage;

(C) reports, including:

(i) Medicare Multiple Policies Report;

(ii) Medicare SELECT Grievance Report;

(iii) Medicare Rate Report;

(iv) Long-Term Care Rate Report; and

(v) Long-Term Care Partnership Agent Training Certification

Form;

(D) certifications related to form filings, readability scores, actuarial memoranda, statements of variability, and small and large employer health benefit plans;

(E) Medicare SELECT plans of operation and amendments;

(F) miscellaneous documents and information necessary to make a filing complete or for a comprehensive review of the filing that are filed in an informational mode; and

(7) other documents subject to filing with the department.

(b) If any provision of this chapter or its application to any person or circumstance is held to be invalid for any reason, the invalidity does not affect the remainder of the subchapter and the application of its provision to any persons under other circumstances. To this end, all provisions of this subchapter are declared to be severable.

### **§3.2. Definitions.**

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

(1) Amendment or endorsement--A form that changes or modifies the provisions of an issued policy, certificate, contract, or evidence of coverage.

(2) Blanket policy or contract--A policy or contract authorized by Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders, and issued to a master group policyholder or contract holder that covers all or nearly all individuals within a described group or class of individuals without requiring the covered individuals to affirmatively enroll or to contribute to the premium.

(3) Complete filing--A filing that meets the requirements in this subchapter.

(4) Commissioner--The Commissioner of Insurance.

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

(6) Disposition--The final status of a filing, which is issued in writing by the department and communicated to the issuer prior to closing the filing. A disposition status may include approved, disapproved, exempt, failed audit, informational, noncompliant, rejected, reviewed, substitution approval, or withdrawn.

(7) Disposition date--The date the department issues a disposition on a filing.

(8) Evidence of coverage--Any certificate, agreement, or contract, including a blended contract, that is issued by an HMO to an enrollee and states the coverage to which the enrollee is entitled.

(9) Exact copy--A filing that, except for the issuer's name, address, telephone number, or other similar identification information, is identical to a form that was previously approved by the department and is still compliant with current statutes and regulations. A braille or foreign-language copy of a form that is a direct translation from the English version of the form is also an exact copy.

(10) Failed audit--A determination made by the department to withdraw a form's exemption based on a determination that the exempted form violates applicable requirements, consistent with Insurance Code §1701.055, concerning Disapproval of a Form or Withdrawal of Approval or Exemption.

(11) Filing--A form filing, rate filing, advertising filing, group eligibility filing, network filing, or informational filing.

(12) Filing ID--A unique identifier assigned to a filing by SERFF (for example, SERFF ID).

(13) Filing types--A designation used to describe the purpose and contents of a filing, which includes form filings, rate filings, advertising filings, network filings, group eligibility filings, and informational filings and the associated categories identified in §3.1(a) of this title (relating to Applicability, Scope, and Severability).

(14) Form--A document required to be filed under Insurance Code §1111A.005, concerning Requirements for Contract Forms, Disclosure Forms, and Advertisements; Insurance Code §1153.051, concerning Filing of Form; Insurance Code §1271.101, concerning Approval of Form of Evidence of Coverage or Group Contract; or Insurance Code §1701.051, concerning Filing Required;

(15) Form number--A unique identifier composed of numbers or letters that is assigned to a unique form.

(16) General use--A filing classification that indicates that the filed forms 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 (for example, 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, or an application that will be used with major medical and dental products).

(17) HMO--A health maintenance organization as defined in Insurance Code §843.002, concerning Definitions.

(18) Incomplete filing--A filing that does not meet the requirements in this subchapter.

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

(20) Issuer--An insurance company or HMO that makes a filing under this subchapter.

(21) Limited, partial refiling--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:

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

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

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

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

(22) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, allowing the flexibility to create multiple policies, evidences of coverage, certificates, contracts, or applications by using numerous combinations of the individual provisions approved.

(23) NAIC--National Association of Insurance Commissioners.

(24) New submission--A filing submission type that is applicable to all filings other than a resubmission subject to Insurance Code §1701.058, concerning Reconsideration of Form.

(25) Personally identifiable information--Facts or details about an individual that can be used either alone or in combination to distinguish the individual's identity, such as:

(A) any individual policyholder, certificate holder, or insured's identification, including name, address, phone number, or email;

(B) social security numbers;

(C) insurance policy, contract, or plan numbers;

(D) identification cards;

(E) debit, credit card, bank account, or routing numbers; or

(F) health information about an individual.

(26) Product--a package of benefits with a discrete set of rating and pricing methodologies that will be offered to a consumer.

(27) Qualified actuary--An actuary that is certified by the American Academy of Actuaries to meet the U.S. Qualification Standards.

(28) Resubmission--A filing submission type that contains corrections made to a form that was previously disapproved or for which approval has been withdrawn, which is submitted within 45 days of the disapproval or withdrawal of approval and consistent with Insurance Code §1701.058.

(29) Rider--A form that changes a policy, group agreement, evidence of coverage, certificate, or contract to add or expand benefits, which may be optional or mandatory, and when used, becomes a part of the policy, evidence of coverage, certificate, or contract.

(30) SERFF--The System for Electronic Rate and Form Filing established by the NAIC.

(31) Submission guide--Documentation provided by the department that includes technical guidance concerning how to submit and classify filings. The submission guide is available on SERFF and on the department's website: [www.tdi.texas.gov](http://www.tdi.texas.gov).

(32) Substitution--A filing that includes a new form that replaces a previously approved or exempted form that has not been and will not be issued or otherwise used in Texas at any time by the issuer and that has a form number that is the same as the form it is replacing.

(33) Withdrawn filing--A filing that is not pending the department's review and is not considered approved or exempted, including a filing that was submitted and subsequently removed from the department's review for any reason, including at the issuer's request, or by the department due to an issuer's failure to respond to a request for information or request for revision.

**Division 2. General Filing Requirements**  
**28 TAC §§3.5 - 3.17**

**§3.5. Submission Requirements.**

(a) Notwithstanding any provision of this title to the contrary, all filings and supporting documentation within the scope of this subchapter must be submitted through SERFF or a subsequent electronic system designated by the department. A reference in this subchapter to SERFF means either SERFF or a subsequent electronic system designated by the department.

(b) If the electronic system designated by the department experiences a system-wide outage for any reason, the deadline of the filing is tolled until the outage is resolved.

The department may designate an alternative submission method for filings and supporting documents during such an outage.

(c) Filings submitted to the department must provide complete and accurate information about the filing and include information in SERFF where applicable fields are available, or in a transmittal checklist uploaded into SERFF as provided in the department's submission guide, provided that the information required to be submitted does not exceed the following:

(1) the issuer's name, address, and identifying information, including the NAIC number, NAIC group number, FEIN, and the issuer's license type and state of domicile;

(2) the contact person information as required by §3.6 of this title (relating to Contact Person; Authorization);

(3) the filing fee required under §3.7 of this title (relating to Filing Fees), if applicable;

(4) an explanation of the purpose and use of the filing as required in §3.8 of this title (relating to Purpose and Use);

(5) a clear designation if the issuer would like to make confidential a specific form, rate, or document in the filing, consistent with §3.9 of this title (relating to Confidential Information in Filings);

(6) the information and certifications required in §3.10 of this title (relating to Filing Modes, Categories, and Certifications);

(7) identification of the unique form number of each form submitted;

(8) a classification of the attributes of the filing and forms included in the filing, consistent with the department's submission guide, including the:

(A) type of filing, consistent with the categories identified in §3.1 of this title (relating to Applicability, Scope, and Severability);

(B) type of submission, including new or resubmission;

(C) requested filing mode, including review and approval, file and use, informational, or exempt, as described in §3.10 of this title;

(D) requested effective date for the filing;

(E) type of product and subtype of product, consistent with the product classification guidance provided in the department's submission guide;

(F) type of form, including policy, certificate, application or enrollment, schedule of benefits, rider, endorsement, outline of coverage, advertising, network access plan, provider contract, provider addendum, provider leasing agreement, and provider directory;

(G) type of rate, including a new or revised rate; and

(H) type of market, including individual, franchise, or group, and if applicable:

(i) size of group, including small, large, or small and large; and

(ii) type of group, including employer, association, trust, discretionary, blanket, or other;

(9) rate filing information for any product for which a rate filing is required;

(10) a statement that the submission will be used on a general-use basis, only with the product being filed, or with previously approved or exempted forms;

(11) in the case of a filing that will be used with previously approved or exempted forms, or other pending filings, include a listing of the following:

(A) the form numbers and filing IDs of the pending or previously approved or exempted forms;

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

(C) for a form approved before January 1, 2012, a copy of the approved or exempted form;

(D) if applicable, the updated list of form numbers with which the previously approved or exempted form is to be used; and

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

(12) an explanation of any variable material as required by §3.12 of this title (relating to Variable Material); and

(13) the Flesch score for each submitted form, consistent with §3.14 of this title (relating to Plain Language and Readability Requirements).

(d) If a form filing is submitted using an exempt, file and use, or resubmission filing mode, or a form is refiled in response to a failed audit, disapproval, or withdrawal of approval, the issuer must include a document demonstrating that the filing complies with applicable law including but not limited to the Insurance Code and the rules and regulations of the department. An issuer must review applicable statutes and rules and make a good faith effort to indicate the page or pages on which the forms demonstrate compliance with each applicable provision or note that a provision is inapplicable. If the issuer believes a provision is inapplicable, the issuer must provide an explanation. TDI has checklists available at [www.tdi.texas.gov/forms/form10.html](http://www.tdi.texas.gov/forms/form10.html) that issuers may use to meet this requirement.

(e) Filings that do not include all information and certifications required under this division will be considered incomplete and will be rejected.

### **§3.6. Contact Person; Authorization.**

An issuer submitting a filing to the department must:

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

(2) provide the contact person's name, address, direct telephone number, and email address;

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

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

(B) authorizes the designee to act on behalf of the issuer with respect to the type of filing; and

(C) is signed by an officer of the issuer or a person with authority to bind the issuer; and

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

### **§3.7. Filing Fees.**

(a) Except as provided in subsection (b) of this section, a fee of \$100 is required for a rate or form filing identified under §3.1(a)(1) or (2) of this of this title (relating to Applicability, Scope, and Severability);

(b) A fee of \$50 is required for an exempt form filing that is made under Insurance Code Chapter 1701, concerning Policy Forms, and Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review); and

(c) No fee is required for advertising, network, group eligibility, or informational filings under §3.1(a)(3) - (6) of this title.

(d) Notwithstanding any provision of this title to the contrary, filing fees required under this section must be paid to the department using the electronic funds transfer

system provided on SERFF or a subsequent electronic payment system designated by the department.

(e) Fees must be paid at the time a filing is accepted for review. If the issuer does not pay the fee within five business days, the department may consider the filing withdrawn from review by the issuer. The department will not give any withdrawn filing consideration until the issuer resubmits as a new filing.

### **§3.8. Purpose and Use.**

(a) Each filing must include an explanation of the purpose and use of the forms, rates, advertising, networks, or other information contained in the filing within the general information section of the filing that includes:

(1) how the contents of the filing will be used (for example, the application will be used on a general-use basis; or used with specific policies, evidences of coverage, or contract forms previously approved or exempted);

(2) the type of coverage addressed by the filing;

(3) any key or unique provisions contained in the filing, including:

(A) for a life or annuity filing, the inclusion of bonus interest, additional interest credits, two-tier values, bail-out, market value adjustments, and long-term care;

(B) for an accident and health filing, the inclusion of preferred or exclusive provider benefits, innovative excepted benefit products, standalone prescription drugs, or innovative benefits in a Medicare supplement policy;

(4) if applicable, how the product will be marketed (for example, direct, agent, or electronic);

(5) if applicable, whether the filing addresses a new program or initiative and, if so, how the program will affect consumers and whether the program or initiative has been filed, approved, or disapproved in other states;

(6) if applicable, to whom the product is to be marketed (for example, specific group types or sizes, 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, concerning Health Benefit Plans for Children); and

(7) if applicable, an indication of whether the filing is prompted by a business change such as an assumption, a name change, or a demutualization/conversion.

### **§3.9. Confidential Information in Filings.**

(a) Except as provided in subsection (b) of this section, each submitted filing, including any supporting information filed, will be open for public inspection through SERFF Public Access (or a subsequent electronic system) as of the date of the filing.

(b) If an issuer believes a portion of the information required to be filed under this subchapter is confidential and excepted from disclosure under Government Code Chapter 552, concerning Public Information, the issuer must use the SERFF confidentiality function to mark as confidential each document that contains information that the issuer believes is confidential and excepted from disclosure. The issuer is not permitted to add password protection or otherwise format a document in a manner that restricts the department's ability to save and review the document.

(c) If the department receives an open records request for information that is filed in SERFF and marked confidential, the department will request an attorney general decision under Government Code Chapter 552 about whether the information falls within one of the exceptions to disclosure under Government Code Chapter 552, Subchapter C, concerning Information Excepted From Required Disclosure.

(d) Issuers may not declare an entire filing confidential. Entire filings marked confidential by the issuer will be rejected under §3.17(c) of this title (relating to Acceptance, Rejection, and Disposition of Filings).

(e) An issuer may also choose to include in the filing a redacted copy of a document that is marked as confidential, which would be available for public access. If included, the document must be clearly marked as a redacted copy.

(f) An issuer must not include a consumer's personally identifiable information in a filing, unless required by law. If such information is required to be included in a filing, the issuer must mark the information as confidential.

### **§3.10. Filing Modes, Categories, and Certifications.**

(a) General certification - all filings. An issuer must include the certifications, attachments, and additional information referred to in this section. All filings must include the following certifications:

(1) the certification is on behalf of the issuer;

(2) the issuer is bound by the certification;

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

(4) the individual making the certification has reviewed the filing;

(5) the information in the filing is correct;

(6) if applicable, the Flesch score of each form is accurately reflected and meets the requirements of §3.14 of this title (relating to Plain Language and Readability Requirements); and

(7) to the best knowledge, information, and belief of the individual making the certification, the filing complies with the Insurance Code and rules applicable to the filing.

(b) Additional certifications. An issuer must include one or more of the following additional certifications as specified in this section:

- (1) no corrections to the form have been requested by the department;
- (2) the form has not been previously disapproved by the department;
- (3) the issuer has reviewed the form to ensure it complies with any new requirements that were established after the date the previous form was approved;
- (4) no changes have been made to the form other than those identified;
- (5) the filing contains corrections to a form that was previously disapproved or for which approval was withdrawn;
- (6) the form is an exact copy of a previously approved form or a direct translation of the form to braille or a foreign language from the English version of the previously approved form and no changes have been made to the form except for changes to the issuer's name, address, telephone number, or other similar identifying information;
- (7) the original version of the form has not been issued or otherwise used in Texas and will not be issued or used in Texas at any time; or
- (8) the form will be marketed only as supplemental coverage.

(c) Requested filing mode and additional certifications. All filings must identify a requested filing mode as described in paragraphs (1) - (4) of this subsection.

(1) Review or approval. The following types of filings must be submitted for review or approval and include the general certification provided in subsection (a) of this section:

(A) a form or rate filing that is subject to review or approval under §3.1(a)(1) or (2) of this title (relating to Applicability, Scope, and Severability), other than a filing made under paragraphs (2) or (3) of this subsection;

(B) an advertising filing that is required to be filed for review under §21.120 of this title (relating to Filing for Review);

(C) a group eligibility filing for review as required under Chapter 21, Subchapter S, of this title (relating to Association Plans); and

(D) a network configuration filing under §3.1(a)(4)(C) of this title.

(2) File and use. A form or rate filing may be submitted in a file-and-use mode as permitted under Insurance Code §1701.052, concerning File and Use. For a file-and-use filing, the issuer must include the general certification provided in subsection (a) of this section and the additional certifications provided in subsections (b)(1) and (2) of this section. The issuer must also demonstrate compliance as required in §3.5(d) of this title (relating to Submission Requirements).

(3) Exempt. A form filing may be submitted in an exempt mode as permitted under Insurance Code §1701.005, concerning Exemptions, and Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review). For an exempt filing, the issuer must include the general certification provided in subsection (a) of this section and the additional certifications in paragraphs (1) and (2) of subsection (b) of this section. The issuer must also demonstrate compliance as required in §3.5(d) of this title and certify that:

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

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

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

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

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

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

(4) Informational. A filing may be identified as informational as specified in in §3.1(a)(6) of this title or if paragraphs (1) - (3) of this subsection do not apply. An informational filing must include the general certification provided in subsection (a) of this section.

(d) Categories. A filing that falls under one of the following categories must include the additional information and certifications listed in that paragraph.

(1) Substantially similar or exact copy filings. A substantially similar or exact copy filing must include the following information and certifications concerning how the forms in the filing relate to the previously approved or exempted forms:

(A) the form number, filing ID, and disposition date of the previously filed form;

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

(C) the additional certifications in subsection (b)(1) - (4) of this section; and

(D) for an exact copy filing, the additional certifications in subsection (b)(6) of this section.

(2) Substitution. A form filing that is a substitution must include the information and certifications required under paragraph (1)(A) - (C) of this subsection concerning how the forms in the filing relate to the previously approved or exempted forms and the additional certification in subsection (b)(7) of this section.

(3) Resubmission. A form filing that is a resubmission must include the information required under paragraph (1)(A) and (B) of this subsection concerning how the forms in the filing relate to the forms that were previously disapproved or for which approval was withdrawn and the additional certifications in subsection (b)(4) and (5) of this section. The issuer must also demonstrate compliance as required in §3.5(d) of this title.

(4) Supplemental. A form filing that provides supplemental coverage under Chapter 3, Subchapter S of this title (relating to Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies) must include the additional certification in subsection (b)(8) of this section.

(5) Matrix or insert pages. A form filing that is identified as including matrix provisions or insert pages must include a certification that when issued, the documents 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.

(6) Advertising. An advertising filing must include the information and certifications required under Chapter 21, Subchapter B of this title (relating to Advertising, Certain Trade Practices, and Solicitation).

(7) Group eligibility. A form filing that is a group eligibility filing must include the information and certifications required under Chapter 21, Subchapter S of this title.

(e) Certification completion and signature. Certifications required under this section must be truthful and completed, signed, and certified by an individual with authority to bind the issuer who is an attorney licensed to practice law in this state, an

actuary familiar with the requirements of the Insurance and Administrative Codes, the chief executive officer of the filing issuer, or another individual designated by the chief executive officer.

### **§3.11. Form and Rate Filing Requirements.**

(a) For a form or rate filing, only one product (including an individual policy or evidence of coverage, group policy and certificate, group agreement and evidence of coverage, and their associated forms or rates) may be submitted in a single filing.

(b) A form submitted for general use with multiple policies, evidences of coverage, or certificates must be filed individually, unless the forms are reasonably related and intended to be used with one or more of the same underlying products.

(c) Each form must prominently display on the cover page or the first page a face page that includes:

(1) the full name of the issuer assuming the risk of the product; and

(2) the complete mailing address of the issuer.

(d) Each form submitted must be designated by a unique form number that:

(1) is sufficient to distinguish it from all other forms used by the issuer;

(2) is shown in the lower left-hand corner of each page of the form, or in the case of a matrix provision, is shown below each matrix provision; and

(3) has the additional identifying form number requirements set forth in §3.5201 of this title (relating to Submission of Form and Rate Filings), if the form is submitted under Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance.

(e) A limited, partial refiling must contain the change and any additional actuarial information necessary for a comprehensive review of the refiling, if applicable.

(f) An amendment to an existing form must be accompanied by a revised version of that form (with a new unique form number) that incorporates the contents of the amendment, unless the amendment does not apply to newly issued forms. For a newly issued policy, certificate, contract, or evidence of coverage, the issuer must issue the revised version of the form.

### **§3.12. Variable Material.**

(a) Variable material generally. An issuer is permitted to file forms, advertising, or provider contracts using variable material to illustrate the ways an issued document may vary from the filed material. An issuer may use variable material to illustrate the range of benefit levels or options that will be offered to consumers or to identify nonsubstantive administrative items in the document, such as phone numbers and addresses. Any variable material must be identified using brackets and reflect the most restrictive option, if applicable, within the range of variability. Variable material may not be used in an issued form. The issued form must clearly state the actual benefits and contract terms.

(b) Statement of variability. When variable material is included in a filing, the issuer must submit a statement of variability to accompany the filing that:

(1) provides a clear explanation of how the material will vary;

(2) explains all variable options or ranges that appear in the brackets on the

form;

(3) uses at least 12-point type; and

(4) contains only one explanation of variable material per footnote or

comment.

(c) Permitted uses of variable material. It is acceptable for:

(1) certain materials to vary due solely to the age, sex, classification of the insured, plan type (such as tax-sheltered annuities under 26 USC §403(b), concerning

Taxability of Beneficiary Under Annuity Purchased by Section 501(c)(3) Organization or Public School, and individual retirement accounts under 26 USC §408, concerning Individual Retirement Accounts), telephone numbers, or addresses; and

(2) forms to show certain product information, including the product marketing name or logo, as variable, provided that, before implementing any change to or addition of a service mark, trademark, or logo, the change has been separately filed and approved as required for the maintenance of the issuer's certificate of authority.

(d) Prohibited uses of variable material. It is not acceptable for:

(1) a unique form number on a form to be bracketed as variable;

(2) the issuer name to be bracketed as variable;

(3) a form to use variability to create different types of products using a single form number, rather than making separate product filings;

(4) a matrix or insert page form to include variable material;

(5) a form to specify a range of variability that exceeds the range supported in the issuer's filed rates or schedule of charges and actuarial memorandum, if applicable;

or

(6) an issuer to use variability to an extent that the department is unable to fully understand how the product will appear when issued.

(e) Fill-in material for life and annuity forms. Life and annuity forms must contain fill-in material for a 35-year-old insured. If the form is not issued at age 35, the fill-in material must contain the youngest issue age. If any form includes reduced death benefits, the fill-in material must include the age with the greatest reduction in benefits at issue. The fill-in material must be for the longest premium paying period available.

(f) Life and annuity standards. For life and annuity forms:

(1) the text and specifications of nonforfeiture assumptions cannot include variable material;

(2) a zero entry in a range of values on the specifications page for tiering levels, expense charges, or other fees applicable under the contract is acceptable; and

(3) a zero entry in a range of values on the specifications page for any benefit or credit provided for in the language of the contract is unacceptable.

(g) Accident and health and HMO standards. For accident and health forms and HMO forms:

(1) It is acceptable for forms to include:

(A) mandated offers of benefits or other optional benefits bracketed as variable material with a clear explanation in the statement of variability that the benefit will be included when elected by the contract holder or policyholder;

(B) variable benefit amounts, deductibles, copayments, and coinsurance ranges that are consistent with the ranges supported in the rates and actuarial memorandum; or

(C) variable dollar or visit maximums with a clear explanation in the statement of variability that states that the minimum statutory or regulatory requirements will always be included in the form.

(2) It is not acceptable for forms to use variable material:

(A) as a means of combining separate types of products under a single form, including preferred provider health benefit plans, exclusive provider health benefit plans, HMO plans, or indemnity plans under a single form;

(B) as a means of combining a standard health benefit plan under Insurance Code Chapter 1507, concerning Consumer Choice of Benefits Plans, with a plan that includes all state mandated benefits under a single form or plan;

(C) as a means of excluding mandated benefits; or

(D) within a provision to which a particular state requirement applies that does not clearly demonstrate compliance with the applicable requirement.

(h) Examples upon request. The department reserves the right to request that the issuer submit examples of issued forms that illustrate the full range of variability.

### **§3.13. Matrix and Insert Page Forms.**

Forms may be submitted as matrix or insert page forms. Any issuer submitting a matrix or insert page form:

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

(A) is sufficient to distinguish it from all other matrix provisions or insert pages used by the issuer; and

(B) is shown in the lower left-hand corner of the matrix provision or insert page;

(2) may use the same matrix provision or insert page form number within multiple products, provided the language is applicable to each product;

(3) must list the form number for each matrix provision or insert page and provide a statement indicating how and with what type of product or products the matrix provision or insert page will be used; and

(4) must provide the certifications required in §3.10(d)(5) of this title (relating to Filing Modes, Categories, and Certifications).

### **§3.14. Plain Language and Readability Requirements.**

(a) Purpose. The purpose of this section is to simplify the contract terms within life and health insurance, HMO, and annuity products issued in Texas. This section establishes plain language requirements and procedures to make contracts easier to read by the public and to remove language that may be unjust, deceptive, misleading, or unreasonably confusing.

(b) Plain language. All filed forms, except for annuity products subject to federal jurisdiction, must be written in plain language and organized in a manner to make it easy for consumers to understand.

(c) Flesch reading ease requirements.

(1) The text of the form must achieve a minimum Flesch reading ease score of 40, calculated using the method described in §3.602(b)(1), (c), and (d) of this title (relating to Plain Language Requirements).

(2) An issuer must submit a certification signed by an officer of the issuer stating the Flesch score of the form when the form is submitted to the department. The department may require the submission of further information to verify the certification of compliance.

(d) Best practices. In determining whether forms are written in plain language and organized in a manner to aid consumer understanding, the department will consider plain language best practices, including:

(1) the use of short, familiar words or words that are used in common speech, rather than the use of jargon or technical terms, and defining technical terms used when necessary;

(2) whether the form is written in a clear and coherent manner;

(3) the unnecessary use of technical or abstract words;

(4) whether short sentences are used in paragraphs limited to a single topic, when possible, rather than the use of complex and compound sentences;

(5) the unnecessary use of prefixes and suffixes;

(6) whether the style, arrangement, and overall appearance of the form gives undue prominence to any portion of the text; and

(7) the organization of the form, including as modified by any rider, endorsement, or amendment, such as:

(A) whether the form is organized in a logical order, with clear sections and headings;

(B) whether the form's coverages are self-contained and independent;

(C) whether the form is appropriately divided and captioned in meaningful sequence, where each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section;

(D) whether the form unnecessarily refers the reader from section to section;

(E) whether general policy provisions applying to all or several like coverages, such as defined words and terms, or limitations and exclusions, are located in a common area and appropriately captioned; and

(F) whether the use of a separate form like an amendment or endorsement to modify a contract, policy, or evidence of coverage will result in confusion about the coverage, particularly if this will occur at the time coverage is first issued.

(e) Definitions. Companies may utilize a separate definition section for words used throughout the policy or evidence of coverage. If a separate definition section is used, it must appear early in the form.

(f) Formatting. The form must:

(1) except for specification pages, schedules, and tables, be printed in not less than 10-point type;

(2) use a font style and size that is easy to read, considering the audience;  
and

(3) use a format that aids readability, with sufficient white space and the use of bulleted or numbered lists when appropriate.

(g) Table of contents. A policy, evidence of coverage, or contract must contain a table of contents or an index of the principal sections if it has more than 3,000 words on three or fewer pages of text or more than three pages, regardless of the number of words.

### **§3.15. Group Filings.**

(a) An issuer submitting a filing for a group policy, agreement, or contract must:

(1) identify the specific group type under which the form is being filed by indicating the appropriate section, as set forth in:

(A) Insurance Code Chapter 1131, Subchapter B, concerning Group and Wholesale, Franchise, or Employee Life Insurance: Eligible Policyholders;

(B) Insurance Code Chapter 1251, Subchapter B, concerning Group Accident and Health Insurance: Eligible Policyholders; or

(C) Insurance Code Chapter 1251, Subchapter H, concerning Blanket Accident and Health Insurance: Eligible Policyholders; and

(2) submit a separate policy, evidence of coverage, group agreement, or certificate, each with a unique identifying form number, for each group type to which the filing will be issued.

(b) For a product issued to an association under Insurance Code §1131.060, concerning Nonprofit Organizations or Associations; §1251.052, concerning Associations; or §1251.358, concerning Association, the issuer must make group eligibility filings as required by Chapter 21, Subchapter S of this title (relating to Association Plans).

(c) For a product to be issued to associations participating in a multiple association trust, the issuer must make a group eligibility filing that includes:

(1) a listing of all the associations participating in the multiple association trust;

(2) a copy of the trust agreement; and

(3) a reference to the unique filing ID or IDs in which the department previously confirmed that each participating association is an eligible group, consistent with Chapter 21, Subchapter S of this title.

(d) An issuer that has received approval for a filing to be issued to associations participating in a multiple association trust must make a group eligibility filing for information to notify the department of any subsequent additions of participating associations upon enrollment and must include the documentation required in subsection (c) of this section for each association that joins the trust after approval of the initial filing.

(e) For a health benefit plan issued to an association under Insurance Code §1251.052, the issuer must:

(1) for a member-only association, identify whether the plan is issued to a member-only bona fide association as defined under §21.2702 of this title (relating to Definitions); or

(2) for an employer association, specify whether the plan will cover small or large employer members and whether the group is considered a bona fide employer association under §26.301 of this title (relating to Applicability, Definitions, and Scope).

(f) For a filing subject to Insurance Code Chapter 1501, concerning Health Insurance Portability and Availability Act, the issuer must specify whether the plan will be issued to small or large employers and must comply with all filing requirements set forth in Chapter 26 of this title (relating to Employer-Related Health Benefit Plan Regulations).

(g) Before issuing a product to a professional employer organization (PEO) as a single large employer, consistent with Labor Code Chapter 91, concerning Professional Employer Organizations, the issuer must make an informational group eligibility filing that includes:

(1) the name and federal employer identification number of the PEO; and

(2) a copy of the PEO's license.

(h) A filing to be issued to an educational institution, if it is issued on a group basis, must be filed under Insurance Code §1131.064, concerning Other Groups, or Insurance Code §1251.056, concerning Other Groups; or, if it is issued on a blanket basis, it must be filed under §1251.353, concerning Educational Institutions.

(i) An issuer licensed in this state that issues a certificate of insurance or evidence of coverage covering a Texas resident is responsible for ensuring that the form complies with applicable Texas insurance laws and rules, regardless of whether the group policy, agreement or contract underlying the certificate or evidence of coverage was issued outside the state. A copy of the master policy, group agreement, or contract issued outside of Texas must accompany any life, annuity, credit, or accident and health certificate, or HMO evidence of coverage filed for review or filed as exempt, along with certification and evidence that the master policy, group agreement, or contract was lawfully issued and delivered in a state in which the issuer was authorized to do business.

(j) A form to be issued to a Texas resident may not rely on an amendment to modify the form to comply with Texas requirements, unless the contract as a whole, including the amendment, meets the plain language requirements provided in §3.14 of this title (relating to Plain Language and Readability Requirements).

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

### **§3.16. Foreign Language Filings.**

(a) A filing that includes a copy of a form in braille or in a foreign language must include a certification as required under §3.10(b)(6) (relating to Filing Modes, Categories, and Certifications) that the form is an exact copy of the English version of the previously approved form.

(b) If filed separately from the English version of the form, the filing must reference the filing in which the English version of the form was filed. A filing that only includes a foreign language version of a previously approved form may be filed in an informational mode and is eligible to be filed in an exempt mode, consistent with Subchapter Z of this chapter (relating to Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review).

### **§3.17. Acceptance, Rejection, and Disposition of Filings.**

(a) Acceptance, approval, and exemption of filings. Upon submission, a filing will be accepted for preliminary review of compliance with the filing requirements in this subchapter. If the filing requirements in this subchapter have not been satisfied, the department will consider the filing incomplete and may reject the filing or request that the issuer make corrections.

(1) Review period for filings subject to approval. Filings subject to approval, whether filed in a review and approval or a file and use mode, will be reviewed for compliance with the Insurance Code, this title, and any other applicable law of this state or the United States. Filings are considered filed as of the date the filing is submitted, unless the filing is rejected as provided in subsection (c) of this section. The filings, after review, will be affirmatively approved or disapproved within the statutory deemer period, if applicable under Insurance Code §1271.102, concerning Procedures for Approval of Form of Evidence of Coverage or Group Contract; Withdrawal of Approval, §1701.054, concerning Approval of Form; or §1701.058, concerning Reconsideration of Form, unless the department initiates a request for correction as set forth in subsection (b) of this section.

(2) Date for exempt filings. As permitted under Subchapter Z of this chapter (relating to Exemption From Review and Approval of Certain Life, Accident, Health, and

Annuity Forms and Expedition of Review), an issuer may submit a filing in an exempt mode. A filing closed with an exempt disposition is considered exempt as of the disposition date, unless the filing is rejected as provided in subsection (c) of this section. Exempt filings are subject to audit as specified in §3.4008 of this title (relating to Procedures for Corrections to Non-Compliant Exempt Forms). If an exempt filing is found to be noncompliant, the department will withdraw the exemption and communicate the failed audit consistent with subsection (e) of this section.

(3) Date for informational filings. A filing submitted in an informational mode will be closed with an informational disposition, unless the department determines that the filing is subject to review. Informational filings are considered filed as of the disposition date unless the filing is rejected as provided in subsection (c) of this section.

(b) Request for correction.

(1) Rather than issuing a disapproval of a filing, the department may request that the issuer make corrections to a form that contains compliance deficiencies if:

(A) for an insurance filing, the issuer, as necessary and no less than seven days before the date the filing is deemed approved:

(i) requests a 45-day extension of the review period; or

(ii) provides a waiver of the issuer's right to deem the filing approved, if applicable; or

(B) for an HMO filing:

(i) the department notifies the issuer that the review period has been postponed, consistent with §11.301(6) of this title (relating to Filing Requirements); or

(ii) the issuer, as necessary and no less than seven days before the date the filing is deemed approved, provides a waiver of the issuer's right to deem the filing approved, consistent with §11.301(7) of this title.

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

(3) The department may notify an issuer of a request for corrections by written or electronic communication.

(4) An issuer submitting a form as a correction to a pending form must provide:

(A) a summary of the differences between the previously reviewed form and the corrected form, including a description of any deleted text, and a clear identification of all changes, with new or modified text redlined; and

(B) a certification that no changes were made to the form other than those identified.

(5) If an issuer fails to submit corrections to the department within 10 business days after the department provides a notice of any deficiencies and request for corrections, the department may consider the filing withdrawn from review by the issuer. The department will not give any withdrawn filing consideration until the issuer resubmits as a new filing.

(c) Rejection of filings.

(1) If the department determines that a filing does not meet the requirements of this subchapter, the department will reject the filing as incomplete and notify the issuer of the reason for rejection or request that the issuer make corrections to the filing. If the issuer does not make corrections within two business days of the department's request for corrections, the department may reject the filing. A filing that is closed with a rejected disposition will not be considered to have been filed with the department for purposes of this subchapter.

(2) The department may reject a filing for failure to comply with any requirement in this subchapter, for example if a filing:

(A) is marked confidential in its entirety;

(B) contains personally identifiable information;

(C) is categorized as substantially similar but the filing is found to contain changes from the previously approved form that are not clearly identified; or

(D) contains a certification that is found not to be truthful.

(3) The department will not reopen a rejected filing to allow the issuer to make corrections. The issuer must submit a new filing for the department to consider any corrections.

(d) Disapproval or withdrawal of approval or exemption.

(1) The department may disapprove, withdraw approval, or withdraw exemption from a form filing, consistent with Insurance Code §1111A.005(c), concerning Requirements for Contract Forms, Disclosure Forms, and Advertisements; Insurance Code §1153.053, concerning Disapproval of Form; Insurance Code §1153.054, concerning Withdrawal of Approval of Form; Insurance Code §1271.102, Insurance Code §1271.103, concerning Withdrawal of Approval of Form; Insurance Code §1701.055, concerning Disapproval of Form or Withdrawal of Approval or Exemption; or Insurance Code §1701.057, concerning Withdrawal of Individual Accident and Health Insurance Policy Form Approval.

(2) If, as permitted under Insurance Code Chapter 1701, concerning Policy Forms, an issuer uses a form before it is approved, the department may order the issuer to replace or amend the form, consistent with Insurance Code §1701.059, concerning Replacement or Amendment of Document.

(e) Departmental notice of action for filings subject to review. The department will send written or electronic notification of any actions taken by the department when it has

completed the processing of the filing. The notice will explain the disposition, as provided in paragraphs (1) - (3) of this subsection, and the effective date of the disposition.

(1) An approved filing disposition will state each approved form number, as applicable.

(2) A disapproved or failed audit filing disposition will be preceded by a notice of proposed negative action at least five days in advance of the effective date of the proposed negative action that states each applicable form number and the compliance deficiencies that form the basis of the proposed disapproval or failed audit. Notice will be provided consistent with Insurance Code §36.102, concerning Summary Procedures for Routine Matters, and Chapter 1, Subchapter F of this title (relating to Summary Procedures for Routine Matters). If an issuer wishes to petition the commissioner for a hearing to review the disapproval or failed audit consistent with §1.705 of this title (relating to Review), they must request a hearing no later than 15 business days after the effective date of a negative action.

(A) For a filing that the department has proposed to disapprove, if the issuer fails to bring the forms into full compliance before the proposed disposition date, the department will close the filing as proposed.

(B) For a filing that has failed audit, the issuer must submit a new filing for review and approval to correct the forms.

(3) A reviewed or noncompliant disposition will be issued for a filing that is not subject to disapproval. Notice of any noncompliant disposition will include an explanation of the changes needed to bring the filing into compliance. An issuer that receives a noncompliant disposition may submit a new filing to correct the issues. An issuer that uses a document that has been determined to be noncompliant may be subject to departmental enforcement action authorized under Insurance Code Chapter 82, concerning Sanctions, or Insurance Code 83, concerning Emergency Cease and Desist

Orders. Notices of acceptance for exemption or filing for information will be in the form of a written or electronic notification stating the form number, if applicable, and the date of acceptance of such filing.

(f) Retention of filings and dispositions. Companies must retain the written notification or a copy of the electronic notification as documentation of the department's action on a form and maintain copies of approved, reviewed, and exempted forms. This requirement no longer applies if there are no lives insured under the form and the issuer has submitted a written or electronic request that the department withdraw approval of the form.

**Division 3. Requirements Relating to Application Form Filings**  
**28 TAC §3.30 and §3.31**

**§3.30. Applications Generally.**

(a) Application forms must include a clear statement specifying:

(1) the purpose or purposes of the application, including the type of contracts and products for which the application will be used; and

(2) whether the application will be in paper, electronic, or telephonic form.

(b) Applications for use by multiple companies or for use in offering products from multiple companies must be submitted to the department by each issuer that will use the form and must prominently display:

(1) the full name of each issuer assuming the risk of the products, and the products offered by each issuer;

(2) the complete mailing address of each issuer; and

(3) a means of designating the appropriate issuer (such as checkboxes) in which coverage is being sought.

(c) Questions that applicants must complete on an application:

(1) must be limited to questions necessary to issue or administer the policy or contract;

(2) may not be structured in a manner that requires the applicant to self-diagnose; and

(3) if limited by time or scope, must be consistent with the underwriting standards.

(d) Application forms must:

(1) include all the sections and questions that may be required to be completed by an applicant, including additional drop-downs, scripts, questions, questionnaires, or supplements that would be required if the applicant answers questions in a certain way, such as a "yes" response;

(2) include the statements an applicant must agree to in order to complete the application;

(3) disclose that the statements and answers in the application are the basis for any policy issued by the issuer;

(4) state that coverage may not be denied on the basis of information not requested in the application except as described in the application;

(5) if the issuer will obtain personal information on the applicant from a third-party information provider, disclose the source of the information and obtain each applicant's authorization to obtain the personal information with respect to a specified duration of time;

(6) disclose that any information obtained from a third-party information provider will be used to underwrite the application; and

(7) include a signature section for the applicants, proposed insureds, and owners.

(e) An application must include disclosures that explain:

(1) any applicable incontestability provision; and

(2) whether the application will be attached to the policy or evidence of coverage and become part of the contract.

**§3.31. Delivery of Applications in Writing; Standards for Electronic and Telephonic Applications.**

(a) When conducting business electronically, an issuer must comply with Insurance Code Chapter 35, concerning Electronic Transactions.

(b) For all applications, including applications that involve electronic or telephonic transactions, the issuer must provide the applicant with a copy of the completed application in writing, including any responses given verbally, before the applicant is asked to sign and submit the application.

(c) The issuer must deliver the completed written application in a manner that allows the consumer to retain the information, consistent with Texas Business Commerce Code §322.008(a), concerning Provision of Information in Writing; Presentation of Records, and Insurance Code §35.004(c), concerning Minimum Standards for Regulated Entities Electronically Conducting Business with Consumers.

(d) When filing an application that will be used with electronic or telephonic transactions, the issuer must include in the filing:

(1) a description of the security procedures that will be used to verify the authenticity of the transaction; and

(2) a "John Doe" sample that shows all sections and questions that the applicant must complete, including any additional drop-downs, scripts, questions, or supplements that may be conditionally required based on the applicant's responses.

**Division 4. Requirements Specific to Accident, Health, and HMO Filings**  
**28 TAC §§3.40 - 3.43**

**§3.40. Separate Filings Required.**

Forms for different types of products that are subject to different regulatory standards must be submitted in separate filings. The different types of products include HMO plans, preferred provider benefit plans, exclusive provider benefit plans, indemnity plans, state-mandated plans, and consumer choice health benefit plans.

**§3.41. Filing Requirements for Health Plan Disclosures.**

(a) A filing for any product for which an outline of coverage, written description of plan terms and conditions, or similar disclosure is required must include a copy of the required disclosure document for review or a reference to the filing ID under which the disclosure document was separately filed. The disclosure document must comply with the applicable requirements, including:

(1) for individual accident and health coverage, the requirements in Subchapter S of this chapter (relating to Minimum Standards and Benefits and Readability for Individual Accident and Health Insurance Policies);

(2) for Medicare supplement coverage, the requirements in §3.3308 of this title (relating to Required Disclosure Provisions);

(3) for short-term limited-duration coverage, the requirements in §3.3602 of this title (relating to Requirements for Short-Term Limited-Duration Coverage);

(4) for a preferred or exclusive provider plan, the requirements in §3.3705 of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(5) for long-term care coverage, the requirements in §3.3832 of this title (relating to Outline of Coverage); or

(6) for an HMO plan, the requirements in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees).

**§3.42. Payment of Premiums or Cost-Sharing.**

(a) In addition to compliance with Insurance Code §1369.0542, concerning Effect of Reductions in Out-of-Pocket Expenses on Cost-Sharing and any other applicable statute or rule, an issuer's restrictions on the form or manner of the payment of premiums or cost sharing for a major medical health insurance, HMO, or Medicare supplement product must:

(1) be disclosed in the contract;

(2) not require payment by personal check;

(3) not impose a surcharge on any form of payment; and

(4) not prohibit payments made by the enrollee, such as by money order,

based on the source of the funds.

(b) An issuer must accept premium and cost-sharing payments made by:

(1) the enrollee's family;

(2) an entity described in 45 CFR §156.1250, concerning Acceptance of

Certain Third Party Payments, as applicable; or

(3) another third party if the following criteria are met:

(A) the assistance is provided based on the insured's financial need;

(B) the individual or organization providing the funds is not a health

care provider; and

(C) the individual or organization providing the funds is not

financially interested. Financially interested individuals or organizations include those that

receive most of their funding from individuals or entities with a pecuniary interest in the payment of health insurance claims, or organizations that are subject to direct or indirect control of individuals or entities with a pecuniary interest in the payment of health insurance claims.

**§3.43. Market Withdrawals; Filings Required for Termination of Guaranteed Renewable Major Medical Coverage.**

(a) Any issuer required to provide notice to the department related to a withdrawal from the market with respect to issuance of guaranteed renewable major medical coverage under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions), §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate), §21.2704 of this title (relating to Mandatory Guaranteed Renewability Provisions for Health Benefit Plans Issued to Members of an Association or Bona Fide Association), §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market), or §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) must submit a filing consistent with this section at least 180 days before coverage under the first plan terminates.

(b) An issuer must submit a filing for each line of business from which the issuer is withdrawing that includes:

(1) whether a withdrawal plan has been submitted under Chapter 7, Subchapter R of this title (relating to Withdrawal Plan Requirements and Procedures) and Insurance Code Chapter 827, concerning Withdrawal and Restriction Plans;

(2) as applicable, the service areas affected by the withdrawal and a reference to filing ID under which the issuer filed the service area reduction;

- (3) the number of covered lives affected in each Texas county;
- (4) the effective date or dates on which coverage will terminate;
- (5) a copy of the notices to be provided to policyholders, group contract holders, and enrollees; and
- (6) a list of products that will be terminated that includes the form numbers and filing IDs.

**Division 5. Actuarial Filing Requirements**  
**28 TAC §§3.50 - 3.52**

**§3.50. General Actuarial Filing Requirements.**

Issuers are required to submit rate filings or other actuarial information as required by:

- (1) Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance;
- (2) Insurance Code Chapter 1107, concerning Standard Nonforfeiture Law for Certain Annuities;
- (3) Insurance Code §1131.064, concerning Other Groups;
- (4) Insurance Code §1153.101, concerning Filing of Schedule of Rates and Subtitle FF of this chapter (relating to Credit Life and Credit Accident and Health Insurance);
- (5) Insurance Code §1251.056, concerning Other Groups;
- (6) Insurance Code §1251.359, concerning Coverage for Other Risks;
- (7) Insurance Code Chapter 1271, Subchapter F, concerning Schedule of Charges, and Chapter 11, Subchapter H of this title (relating to Schedule of Charges);

(8) Insurance Code Chapter 1501, Subchapter E, concerning Underwriting and Rating of Small Employer Health Benefit Plans, and §26.11 of this title (relating to Restrictions Relating to Premium Rates);

(9) Insurance Code Chapter 1651, concerning Long-Term Care Benefit Plans, and Subchapter Y of this chapter (relating to 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);

(10) Insurance Code Chapter 1652, concerning Medicare Supplement Benefit Plans, and Subchapter T of this chapter (relating to Minimum Standards for Medicare Supplement Policies);

(11) Insurance Code Chapter 1698, concerning Rates for Certain Coverage, and Subchapter F of this chapter (relating to Rate Review for Health Benefit Plans);

(12) Insurance Code §1701.057, concerning Withdrawal of Individual Accident and Health Insurance Policy Form Approval; and

(13) any other applicable statute or rule.

**§3.51. Actuarial Information for Accident and Health Filings.**

(a) This section applies to:

(1) individual accident and health rate filings required under Insurance Code §1701.057, concerning Withdrawal of Individual Accident and Health Insurance Policy Form Approval, including:

(A) major medical coverage, except as provided by subsection (b) of this section;

(B) hospital indemnity;

(C) other fixed indemnity;

(D) cancer and specified disease;

(E) accident only;

(F) accidental death and dismemberment;

(G) disability;

(H) conversion;

(I) supplemental;

(J) dental; and

(K) vision;

(2) except as provided by subsection (b) of this section, small employer major medical coverage, in addition to the requirements contained in Chapter 26 of this title (relating to Employer-Related Health Benefit Plan Regulations); and

(3) group accident and health rate filings required in connection with coverage issued to alternative types of group policyholders under Insurance Code §1251.056, concerning Other Groups, and §1251.359, concerning Coverage for Other Risks.

(b) This section does not apply to rate filings specified in §3.50(7) or (9) - (11) of this title (relating to General Actuarial Filing Requirements).

(c) No premium rate schedule may be used until a copy of such schedule has been filed with the department.

(d) Each premium rate schedule must be accompanied by an actuarial memorandum, signed by a qualified actuary.

(e) Rate filing submissions for a new product must include:

(1) form numbers to which the rates apply and the filing ID under which the forms were filed, approved, or exempted;

(2) a new rate sheet that includes rates for each plan and each combination of rating factors used by the issuer;

(3) an actuarial memorandum that contains:

(A) a brief description of the policy benefits, renewability provision, and general marketing method;

(B) a brief description of how rates were determined, including a general description and source of each assumption used;

(C) a list of retention components, including, expenses, taxes, fees, and profit expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

(D) the target loss ratio, including a brief description of how it was calculated, and all components used in its calculation;

(E) a description of the experience used in developing the issuer's rates, including the level of credibility and appropriateness of experience data or justification for the use of the proposed manual rates if the issuer's own experience is not credible;

(F) assumptions and support used in developing rates, including, adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits; and

(G) any other data used to support the proposed rate.

(f) Rate adjustment filings for an existing product must include:

(1) form numbers to which the rate adjustments apply and filing IDs under which the forms were filed, approved, or exempted;

(2) a new rate sheet that includes rates for each plan and each combination of rating factors used by the issuer;

(3) an actuarial memorandum that contains:

(A) a brief description of the benefits, renewability provision, and the general marketing method;

(B) scope and reason for the rate revision;

(C) a description of the experience used in developing the issuer's rates, including past experience, loss ratios for all applicable prior experience periods, and the level of credibility and appropriateness of experience data;

(D) a brief description of how revised rates were determined, including a general description and source of each assumption used;

(E) a list of expenses, taxes, fees, and profit, expressed as a percent of premium, dollars per policy, or dollars per unit of benefit;

(F) the target loss ratio and description of how it was calculated;

(G) assumptions and support used in developing rates, including adjustments for trend, morbidity, lapses, risk-mitigating programs, and changes in benefits; and

(H) any other data used to support the proposed rate increase.

### **§3.52. Actuarial Information for Life and Annuity Filings.**

(a) For each life filing, including a rider, insert page, or limited partial refiling, that changes the nonforfeiture values of a particular policy or certificate, the issuer must include the actuarial information required by paragraphs (1) - (4) of this subsection.

(1) The filing must include the mathematical formulas and sample calculations as follows:

(A) net premiums for the fill-in age and plan of insurance;

(B) fill-in nonforfeiture calculations necessary to verify consistency between the nonforfeiture values and the text of the form for years one, 20, and 50;

(C) terminal reserves for the fill-in age and plan; and

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

(2) For universal life and interest-sensitive forms, the issuer must include an actuarial memorandum that provides 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. For a change in basic coverage, bands and risk classes for all ages must be provided. The issuer must also:

(A) provide actuarial proof that:

(I) cash surrender values meet the minimum requirements of Insurance Code Chapter 1105, concerning Standard Nonforfeiture Law for Life Insurance; and

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

(B) provide a comparison table of all guaranteed cash surrender values, standard nonforfeiture law minimum cash surrender values, guaranteed death benefits, and reserves. Such comparison should be based on the fill-in issue age (usually age 35) as defined in §3.12(e) of this title (relating to Variable Material), a premium that will provide coverage to the latest available maturity date, the minimum issue amount, minimum guaranteed interest rates, maximum guaranteed cost of insurance rates (mortality rates), maximum guaranteed charges, and a month-by-month calculation of the values shown in the comparison for the first and 50th years.

(3) For variable life forms, the issuer must provide actuarial information as required by §3.804 of this title (relating to Insurance Contract and Filing Requirements), and as required by this section.

(4) The issuer must provide a statement certifying that all policies or certificates will have premiums, reserves, and nonforfeiture values calculated in a manner

consistent with the information furnished. Any qualifications to the certification must be specified, including any variation in formulas at different ages at issue or at time of a change.

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

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

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

(A) identify the name of the separate account;

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

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

(D) include a table of minimum guaranteed policy values and cash surrender values that:

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

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

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

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

(c) For a filing that includes more than one guaranteed interest charge period, the actuarial memorandum must address each guaranteed interest charge period.

**Subchapter Z. Exemption from Review and Approval of Certain Life, Accident, Health, and Annuity Forms and Expedition of Review  
28 TAC §§3.4004, 3.4005, and 3.4009**

**§3.4004. Exempt Forms.**

(a) Group and individual life forms. The group and individual life insurance forms specified in this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, concerning Policy Forms, 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 and individual term life insurance forms [~~master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto,~~] issued under [~~the authority of~~] Insurance Code §§1131.003, concerning Certain Wholesale, Franchise, or Employee Life Insurance Authorized; 1131.051, concerning Employers; 1131.052, concerning Labor Unions; 1131.053, concerning Funds Established By Employers or Labor Unions; 1131.054, concerning Governmental Entities or Associations of Public Employees; 1131.055,

concerning Spouses and Children of Employees of United States Government; 1131.056, concerning Principals; 1131.057, concerning Creditors; [-] 1131.058, concerning Veterans' Land Board; and 1131.060, concerning Nonprofit Organizations or Associations; [- and 1131.064(b), listed in subparagraphs (A) and (B) of this paragraph:]

~~[(A) term policies and riders; and]~~

~~[(B) cash value and endowment policies with no more than five death benefit and/or premium changes;]~~

~~[(2) any alternate face pages filed subsequent to the original approval of a policy for use with multiple employer trusteed arrangements as defined in Insurance Code §1131.053;]~~

~~[(3) individual, joint life, and last survivor insurance forms, including applications, listed in subparagraphs (A) - (Q) of this paragraph:]~~

~~[(A) ordinary life;]~~

~~[(B) limited pay life with no more than five death benefit and/or premium changes;]~~

~~[(C) life paid up at specified ages with no more than five death benefit and/or premium changes;]~~

~~[(D) single premium life with no more than five death benefit changes;]~~

~~[(E) modified premium level death benefit life with no more than five premium changes;]~~

~~[(F) level premium life with no more than five death benefit changes;]~~

~~[(G) retirement income policies;]~~

~~[(H) level or decreasing term policies and riders;]~~

~~[(I) increasing term policies and riders;]~~

~~[(J) family plans;]~~

~~[(K) family income;]~~

~~[(L) family plan riders, including but not limited to children's term riders, dependent term riders, and spouse term riders;]~~

~~[(M) limited pay endowment with no more than five death benefit and/or premium changes;]~~

~~[(N) level premium endowment with no more than five death benefit changes;]~~

~~[(O) single premium endowment with no more than five death benefit changes;]~~

~~[(P) indeterminate premium policies with no more than five death benefit changes; and]~~

~~[(Q) variable life policies with a separate account only;]~~

(2) ~~[(4)]~~ rider forms listed in subparagraphs (A) - (K) of this paragraph:

(A) accidental death benefit riders;

(B) waiver of premium riders;

(C) guaranteed insurability riders;

(D) individual retirement account ~~[accounts]~~ (IRA) riders (to include Roth and Simple IRAs ~~[IRA]~~) ~~[riders]~~;

(E) preliminary term riders;

(F) conversion riders;

(G) exchange riders;

(H) waiver of cost riders, including waiver of cost and monthly expense charge, and waiver of cost and premium payment;

(I) dividend option riders;

(J) additional insured riders; and

(K) additional insurance on base insured riders;

(3) ~~(5)~~ endorsement forms listed in subparagraphs (A) - (K) of this paragraph:

- (A) ORP endorsements;
- (B) nontransferability endorsements;
- (C) H.R. 10 endorsements;
- (D) tax sheltered annuity endorsements;
- (E) nonassignability endorsements;
- (F) settlement option endorsements;
- (G) individual retirement account endorsements (to include Roth and Simple IRA endorsements);
- (H) unisex endorsements;
- (I) loan endorsements;
- (J) waiver of surrender charges on disability or confinement in a hospital or nursing home endorsements; and
- (K) step-up or roll-up death benefit endorsements;

(4) ~~(6)~~ limited refilings for ~~[life insurance which indicate only a change in the mortality table or interest rates for new issues under the policy form, or]~~ changes to the separate account for variable products.

(b) Exceptions. A filing identified in [The provisions of] subsection (a)(1) [and (2)] of this section is not permitted to be filed as exempt for [do not apply to] any group or individual life insurance forms providing the types of coverages set out in paragraphs (1) - (13) ~~(12)~~ of this subsection:

- (1) universal life;
- (2) universal related life;
- (3) adjustable life;
- (4) variable life with a fixed account;

(5) business value;

(6) any forms containing a market value adjustment;

(7) deposit term;

(8) forms subject to Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance;

(9) any life insurance product used to fund prepaid funeral contracts;

(10) any form containing a persistency bonus provision, no-lapse premium provision, or other additional interest credit to the policy value provision (guaranteed or non-guaranteed), equity indexed provision, residual death benefit provision, accelerated death benefit provision, long-term care or other accident- and health-related [~~accident and health-related~~] benefit provision;

(11) applications for use with variable life or equity indexed life, or forms that contain a market value adjustment provision, a long-term care or other accident- and health-related [~~accident and health-related~~] benefit provision; [~~or~~]

(12) group life master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §1131.064, concerning Other Groups, that are related [~~relating~~] to discretionary groups; or

(13) limited refilings for life insurance that indicate a change in the mortality table or interest rates for new issues under the policy form.

(c) Group and individual annuity forms. The group and individual annuity forms [~~including applications,~~] specified in paragraphs (1) - (7) of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, concerning Policy Forms, unless the forms are required by the laws of Texas, another state, or of the United States to be specifically approved or are otherwise excepted in subsection (d) of this section:

(1) single premium immediate annuities (including variable immediate annuities);

(2) deferred annuities used as structured settlement options;

(3) individual deferred annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability or confinement in a hospital or nursing home); two-tier values; or a market value adjustment:

(A) for purposes of this paragraph, and paragraph (4) of this subsection, "waiver of surrender charges" means a waiver of surrender charges that ~~which~~ is applied to any amount greater than 10% of the surrender value;

(B) for purposes of this paragraph, and paragraph (4) of this subsection, "two-tier values" means values on an annuity available at the maturity date of the contract that ~~which~~ are different, depending on whether the value is taken from the contract in a lump sum or left with the issuer for periodic payments, regardless of whether the different values are available at issue or later;

(4) group annuities that do not include persistency bonuses or additional interest credits of any type, waiver of surrender charges (except for death, disability or confinement in a hospital or nursing home), two-tier values, or a market value adjustment; group annuities that are guaranteed investment contracts (GICs), synthetic GICs, funding agreements, and unallocated group annuities funding pension plans;

(5) limited refilings for annuity products which indicate only a change in the mortality table or interest rates for new issues under the policy form; ~~[-or changes to the separate account for variable products;]~~

(6) variable annuities with a separate account only, which do not include a provision for guaranteed living benefits; and

(7) reversionary annuities.

(d) Exceptions. A filing identified in [The provisions of] subsection (c) of this section may not be filed as exempt for [do not include] any of the following annuity forms:

- (1) annuities used to fund prepaid funeral contracts;
- (2) variable annuities that contain guaranteed living benefit provisions;
- (3) annuities that contain an index-linked crediting [equity indexed], long-term care or other accident- and health-related benefit provision;
- (4) applications for use with variable annuities, index-linked crediting [equity indexed] annuities, annuities that contain a market value adjustment provision, long-term care or other accident- and health-related provision;
- (5) group annuity master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under the authority of Insurance Code §1131.064, relating to discretionary groups;[:]
- (6) contingent deferred annuities; or
- (7) limited refilings for annuities that indicate a change in the mortality table or interest rates for new issues under the policy form.

(e) Group and individual accident and health forms. The group and individual accident and health insurance forms specified in paragraphs (1) and (2) [(1)–(3)] of this subsection are exempt from the review and approval requirements of Insurance Code Chapter 1701, unless the forms are required by the laws of Texas, another state, or the United States, to be specifically approved or are otherwise excepted in subsection (f) of this section:

- (1) the group [and blanket] accident and health forms set out in subparagraphs (A) - (C) [(D)] of this paragraph:
  - (A) a [any] group accident and health form [master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto] issued to employers under [authority of] Insurance Code §1251.051,

concerning Employers, or to a labor union or association of labor unions [and §1251.052; provided the forms issued] under [authority of] Insurance Code §1251.052, concerning Associations [are exempt only if delivered or issued for delivery to a labor union or organization of labor unions];

~~[(B) any blanket accident and health master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto, issued under authority of Insurance Code §§1251.351 - 1251.358;]~~

(B) [(C) any] group forms [master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto,] issued under [the authority of] Insurance Code §§1251.051;[.] 1251.052;[.] or 1251.053, concerning Funds Established by Employers, Labor Unions, or Associations, respectively, that provide [providing] Medicare Supplement coverage to an employer, multiple employer arrangement, or a labor union and that are exempt from regulation under Insurance Code §1652.002(b)(1), concerning Medicare Supplement Benefit Plan;

(C) [(D) any] group forms [master policies, contracts, certificates, applications, enrollment forms, riders, amendments, and endorsements applicable thereto,] issued under [the authority of] Insurance Code §1251.051 and §1251.052, that provide [providing] long-term care coverage to a single employer, [or] a labor union, or an association of labor unions through a policy that [which] is delivered or issued for delivery outside of Texas;

(2) group and individual accident and [or] health forms that provide the following coverages: [policies, contracts, certificates, applications, enrollment forms, riders, amendments, endorsements, and related forms (including but not limited to outlines of coverage, notices, rates, and conditional receipts) applicable thereto, providing coverages set forth in subparagraphs (A) - (K) of this paragraph:]

(A) accident only (including occupational accident and other specified accident);

(B) accidental death and dismemberment;

(C) hospital indemnity ~~[dental];~~

~~[(D) in-patient confinement and basic hospital expense coverages (including policies with coverage on an indemnity or expense incurred basis);]~~

(D) ~~[(E)]~~ vision;

(E) ~~[(F)]~~ specified disease (including cancer, heart attack, stroke, and other specifically named diseases);

(F) ~~[(G)]~~ disability coverages (including but not limited to income replacement, key-man, buy/sell, and overhead expense);

(G) ~~[(H)]~~ policies designed to provide conversion coverages;

(H) ~~[(I)]~~ other permitted coverages which are designed to supplement other in-force health insurance ~~[, including Champus supplements];~~ and

(I) ~~[(J)]~~ group stop loss/excess loss policies containing an attachment point of \$5,000 or more. ~~[-and]~~

~~[(K) prescription drug policies; and]~~

~~[(3) any alternate face pages filed subsequent to the original approval of a policy for use with multiple employer trusteed arrangements as defined in Insurance Code §1251.053.]~~

(f) Exceptions. A filing identified in ~~[The provisions of]~~ subsection (e) of this section is not permitted to be filed as exempt for ~~[shall not apply to]~~ any of the following insurance forms or rates: ~~[set out in paragraphs (1)–(6) of this section.]~~

(1) a ~~[The provisions of subsection (e)(2) of this section do not apply to any]~~ group or individual health insurance policy that ~~[which]~~ provides, on a comprehensive basis for illness and injury, a combination of hospital, medical, and surgical coverages,

including but not limited to any guaranteed renewable or short-term limited-duration 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) a ~~[The provisions of subsection (e)(1) and (2) of this section do not apply to any]~~ Medicare supplement policy ~~[policies]~~ as defined in Insurance Code Chapter 1652 concerning Medicare Supplement Benefit Plans, except as specifically provided in subsection (e)(1)(C) of this section; ~~[-]~~

(3) a ~~[The provisions of subsection (e)(1) and (2) of this section do not apply to any]~~ long-term care policy ~~[policies]~~ as defined in Insurance Code Chapter 1651, concerning Long-Term Care Benefit Plans, (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) a form containing ~~[The provisions of subsection (e)(1) and (2) of this section do not apply to any forms which contain]~~ preferred provider or exclusive provider benefit plan provisions as defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; ~~[§§3.3701 - 3.3706 of this title (relating to Preferred Provider Plans)].~~

(5) a ~~[The provisions of subsection (e)(1) and (2) of this section do not apply to any]~~ group form that is ~~[forms which are]~~ issued under ~~[the authority of]~~ Insurance Code §1251.056, concerning Other Groups; ~~[(discretionary groups)].~~

(6) a conversion ~~[The provisions of subsection (e)(2)(H) of this section do not apply to any]~~ policy subject to the provisions of Chapter 21, Subchapter SS of this title, (relating to Continuation and Conversion Provisions) ~~[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; ~~[-]~~

(7) a policy of "other fixed indemnity coverage" that is more extensive than coverage for hospital confinement, including a policy that provides limited long-term care coverage for a period of less than 12 months;

(8) a rate filing that is required to be filed, even if the form is filed exempt as permitted by this section;

(9) a group eligibility filing, even if the form is filed exempt as permitted by this section;

(10) a dental policy; or

(11) an alternate face page filed after the original approval of a policy for use with a multiple employer trust.

(g) Copies of Previously Approved Forms. Except for filings not eligible to be filed exempt under subsection (f)(4) of this section, a [Any] form not otherwise exempted under this subchapter that is an exact copy of a [previously approved] form is exempt from the review and approval requirements of Insurance Code Chapter 1701. Such forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings). [The certification form required to be used in filing the certification is "TEXAS POLICY FORM CERTIFICATIONS, Multi-Use Form," which also is to be utilized for filing certifications for file and use under Insurance Code §1701.052, as well as for corrections, resubmissions, substitutions, and filings for forms exempted from review and official action by this subchapter. Form "TEXAS POLICY FORM CERTIFICATIONS" is available from the Life and Health Division, has been filed with the Texas Register Division of the Secretary of State for public inspection, and is adopted by reference in this subchapter. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating to Appendix).]

(h) Copies of previously approved forms subsequently submitted in foreign language (non-English). Any form not otherwise exempted under this subchapter that is submitted in Braille as an exact copy of a previously approved form, or any form that has been translated into a foreign language from its previously approved English version, is exempt from the review and approval requirements of Insurance Code Chapter 1701. Such forms must be filed in accordance with and accompanied by the required certification as prescribed in Subchapter A of this chapter. ~~[The certification form required to be used in filing the certification is the same as that described in subsection (g) of this section.]~~

### **§3.4005. General Information.**

(a) This section does not relieve any insurer or other licensee from complying with the Insurance Code or the rules and regulations of the Texas Department of Insurance.

(b) Insurers must cause all forms to comply with all required provisions of all applicable law including but not limited to the Insurance Code and the rules and regulations of the department. In addition to other legal requirements:

(1) forms may not contain any ambiguous, deceptive, misleading, unfair, inequitable, or unjust wording or terminology;

(2) title headings or other indications of a form's provisions may not be misleading;

(3) forms may not contain any exception, exclusion, limitation, or reduction that is deceptive, unjust, unfair, encourages misrepresentation, or inequitable or that would deceptively affect the risk purported to be assumed in the general coverage of the contract; and

(4) forms may not be printed or otherwise reproduced in such a manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision.

(c) Every filing exempted from review by this subchapter must be accompanied by each item of information set out in paragraphs (1) - (3) of this subsection.

(1) The certifications for exempt filings required in §3.10 of this title (relating to Filing Modes, Categories, and Certifications). ~~[A signed copy of the certification form which is entitled "TEXAS POLICY FORM CERTIFICATIONS, Multi-Use Form," which also is to be utilized for filing certifications for file and use under Insurance Code §1701.052, as well as for corrections, resubmissions, substitutions, and filings for previously approved similar forms. Form "TEXAS POLICY FORM CERTIFICATIONS" is available from the Life and Health Division, has been filed with the Texas Register Division of the Secretary of State for public inspection, and is adopted by reference in this subchapter. The form also is reproduced in full as Figure 1 in §3.4020 of this title (relating to Appendix).]~~

(2) Any additional information or documentation generally required under the provisions of Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) A cover letter setting out the items in subparagraphs (A) - (C) of this paragraph, as follows:

(A) that the filing is exempt;

(B) the particular section, subsection, paragraph, and subparagraph of the section under which the filing is exempt; and

(C) a brief description of the benefits provided by the form.

### **§3.4009. Sanctions and Cancellation of Exempt Filing Privileges.**

(a) The privileges under this subchapter that permit an insurer to make exempt filings may be ~~[these sections are]~~ canceled ~~[for an insurer]~~ if the insurer makes an exempt filing that fails to comply with one or more provisions of this title or the Insurance Code that results in the department determining that the filing has failed audit. The department

will issue a notice of failed audit consistent with §3.17 of this title (relating to Acceptance, Rejection, and Disposition of Filings) that explains: ~~[either of the determinations in paragraphs (1) or (2) of this subsection are made after notice and hearing as follows:]~~

(1) the compliance deficiencies identified during the audit process;

(2) the corrective action required;

(3) the cancellation of the insurer's exempt filing privileges; and

(4) how those privileges may be reinstated.

~~[(1) an insurer's filing made under §3.4004 of this title (relating to Exempt Forms) fails to comply with §3.4005 of this title (relating to General Information); or]~~

~~[(2) an insurer's filing made under §3.4004(g) of this title fails to be an exact copy of a filing previously approved.]~~

(b) If an insurer's privileges to make exempt filings under this subchapter are cancelled ~~[In the event of cancellation of privileges under these sections],~~ the insurer is ~~[henceforth]~~ required to file for review and approval any and all forms intended for use in Texas, until the ~~[such time as]~~ privileges under these sections are reinstated.

(c) Reinstatement of any privilege canceled under these sections will occur after a period of not more than one year, as provided in the notice of failed audit under subsection (a) of this section ~~[from the date the privileges finally terminate, unless otherwise determined by the commissioner]~~. An insurer may make application for reinstatement prior to the passage of the period specified in the notice of failed audit under subsection (a) of this section ~~[one year following the termination of such privileges]~~.

(d) Nothing in these sections limits the commissioner from imposing any other sanction authorized by the Insurance Code or other applicable law.

**Subchapter Z. Exemption from Review and Approval of Certain Life, Accident,  
Health, and Annuity Forms and Expedition of Review  
Repeal of §3.4020**

**§3.4020. Appendix.**

**Chapter 7. Corporate and Financial Regulation  
Subchapter M. Regulatory Fees  
28 TAC §7.1301**

**§7.1301. Regulatory Fees.**

(a) Regulated entities subject to fees. The regulated entities subject to the fees imposed by this section include all authorized insurers writing any class of insurance in this state that [which] are regulated by Insurance Code Title 2, concerning Texas Department of Insurance; Title 6, concerning Organization of Insurers and Related Entities; Title 7, concerning Life Insurance and Annuities; Title 8, concerning Health Insurance and Other Health Coverages; Title 9, concerning Provisions Applicable to Life and Health Coverages; Title 10, concerning Property and Casualty Insurance; Title 11, concerning Title Insurance, and Title 12, concerning Other Coverage [Titles 2 and 6—12]. For filings and other actions received by the Texas Department of Insurance (department) on and after the effective date of this section, the [~~Texas Department of Insurance (department)~~] will charge these entities fees in amounts in accordance with the provisions of this section. Filings or other actions received by the department before the effective date of this section will be governed by this subchapter as it existed immediately prior to that date.

(b) Fees for insurers with annual gross premium receipts less than \$450,000. As provided in Insurance Code §202.004, concerning Reduced Fees for Certain Insurers, any insurer to which Insurance Code Chapter 202, concerning Fees, applies and whose gross

premium receipts are less than \$450,000 according to its annual statement for the preceding year ending December 31, is required to pay only one-half the amount of the fees required to be paid under subsection (d) or subsection (e) of this section. The fees will be collected at the higher rate unless the applicant can provide the department with satisfactory documentation that gross premium receipts were less than \$450,000.

(c) Fees for specified filings pursuant to Insurance Code Chapter 1701, concerning Policy Forms. Fees for specified filings pursuant to Insurance Code Chapter 1701 are set forth in and governed by Chapter 3, Subchapter A of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(d) Fees for authorized insurers writing classes of insurance in this state that are regulated by Insurance Code Titles 2 and 6 - 12. For the following filings and actions, the fees are as follows.

(1) For classes of insurance for which statutory authority exists for collecting annual statement fees, the fee for filing annual statements is \$250 unless otherwise specified.

(2) For filing amendments to certificate of authority if charter is not amended, the fee is \$0.

(3) For reservation of name, the fee is \$0.

(4) For renewal of reservation of name, the fee is \$0.

(5) For filing application for admission of a foreign or alien insurance company, including issuance of certificate of authority, the fee is \$0.

(6) For filing original charter, including issuance of certificate of authority, the fee is \$0.

(7) For filing amendment to charter, including issuance of certificate of authority, if a hearing is held, the fee is \$0.

(8) For filing amendment to charter, including issuance of certificate of authority, if a hearing is not held, the fee is \$0.

(9) For filing designation of attorney for service of process or amendment to that [thereto], the fee is \$0.

(10) For filing a total reinsurance agreement, the fee is \$0.

(11) For filing a partial reinsurance agreement, the fee is \$0.

(12) For filing a direct reinsurance agreement under [pursuant to] Insurance Code Chapter 884, Subchapter K, concerning Direct Reinsurance Agreements, the fee is \$0.

(13) For filing for approval of reinsurance agreement under [pursuant to] Insurance Code Chapter 828, concerning Purchase of Stock for Total Assumption Reinsurance, the fee is \$0.

(14) For filing for approval of merger under [pursuant to] Insurance Code Chapter 824, concerning Merger and Consolidation of Stock Insurance Corporations, the fee is \$0.

(15) For accepting a security deposit, excluding deposits made under [pursuant to] Insurance Code §425.002, concerning Certain Insurers: Deposit of Securities, Money, or Property in Amount of Legal Reserves, the fee is \$0.

(16) For substitution/amendment of a security deposit, excluding deposits made under [pursuant to] Insurance Code §425.002, the fee is \$0.

(17) For certification of statutory deposit, the fee is \$0.

(18) For filing notice of intent to relocate the books/records under [pursuant to] Insurance Code Chapter 803, concerning Location of Books, Records, Accounts, and Offices Outside of This State, the fee is \$0.

(19) For filing restated articles of incorporation for domestic/foreign companies, the fee is \$0.

(20) For filing a statement under ~~[pursuant to]~~ Insurance Code Chapter 823, Subchapter D, concerning Control of Domestic Insurer; Acquisition or Merger, and Subchapter E, concerning Acquisition Statement, ~~[Subchapters D and E]~~ for the first \$9,900,000 of the purchase price or consideration, the fee is \$0.

(21) For filing a statement under ~~[pursuant to]~~ Insurance Code Chapter 823, Subchapters D and E, if the purchase price or consideration exceeds \$9,900,000, the fee is \$0.

(22) For filing registration statement under ~~[pursuant to]~~ Insurance Code Chapter 823, Subchapter B, concerning Registration, the fee is \$0.

(23) For filing for review under ~~[pursuant to]~~ Insurance Code Chapter 823, Subchapter C, concerning Transactions of Registered Insurer, or Chapter 884, Subchapter L, concerning Direct Reinsurance Agreements with Mutual Assessment Companies, the fee is \$0.

(24) For filing for an exemption under ~~[pursuant to]~~ Insurance Code §823.164, concerning Exemptions from Subchapter, the fee is \$0.

(e) Other fees established by Insurance Code Chapter 202. For the following filings, the fee is as follows.

(1) For filing joint control agreement, the fee is \$0.

(2) For filing substitution/amendment to the joint control agreement, the fee is \$0.

(3) For filing a change in attorney in fact, the fee is \$0.

(f) Administrative procedures.

(1) When a reinsurance agreement or merger agreement is filed with the department, as enumerated in subsection (d)(10) - (14) of this section, the appropriate fee will be determined based on the ceding or merged company.

(2) The fee relating to reinsurance transactions entered into under ~~pursuant to~~ Insurance Code Chapter 823, Subchapter C, and subsection (d)(23) of this section will be ~~determined~~ based on the ceding company.

(3) When an amendment to a reinsurance agreement between affiliated insurers is filed with the department, as mentioned in paragraph (1) of this subsection, the appropriate fee will be based on the ceding company.

(4) An amendment to the charter would constitute any change in the original charter, including ~~[, but not limited to,]~~ name change, home office change, increase in capital, conversion, and increase in lines.

(5) The fee relating to affixing the official seal and certifying to the seal will be applied to all requests for certification, irrespective of requesting party.

(6) The fees for filing an acquisition statement under ~~pursuant to~~ Insurance Code Chapter 823, Subchapters D and E, and subsection (d)(20) and (21) of this section will apply to and be collected from the applicant whenever:

(A) the applicant is a regulated entity subject to this section; or

(B) the company being acquired is a regulated entity subject to this

section.

(g) Fees under ~~pursuant to~~ the Texas Health Maintenance Organization Act, Insurance Code Chapter 843, concerning Health Maintenance Organizations. For the following filings and actions, the fees are as follows.

(1) For filing original application for certificate of authority, the fee is \$0.

(2) For filing annual report, the fee is \$250.

(3) For all examinations made on behalf of the State of Texas by the department or under its authority, the fee will be an amount the commissioner certifies to be just and reasonable.

(4) For a filing requiring approval under §11.301(4)(A) and (B) of this title (relating to Filing Requirements) or a filing for information under §11.301(5)(A) and (B) of this title, fees are set forth in and governed by Chapter 3, Subchapter A of this title [~~evidence of coverage which requires approval, the fee is \$100~~].

~~[(5) For filing required by rule but which does not require approval, the fee is \$50.]~~

(h) Fees for filings pursuant to Insurance Code Chapter 1153, concerning Credit Life Insurance and Credit Accident and Health Insurance. Fees for filings pursuant to Insurance Code Chapter 1153 are set forth in and governed by Chapter 3, Subchapter A of this title.

(i) Fee for filing an annual statement under Insurance Code Chapter 841, concerning Life, Health, or Accident Insurance Companies. The fee for filing an annual statement is \$250.

### **Subchapter M. Regulatory Fees Repeal of §7.1302**

#### **§7.1302. Billing System.**